

Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF NOVEMBER 10, 1958

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welcome relief of spasm and pain is continuously reported in functional G-I disorders, such as irritable,

spastic colon syndrome; peptic ulcer; biliary dyskinesia; pylorospasm; and infant colic.

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relief of g-i spasm & pain

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1. Chamberlain, D. T.;
Gastroenterology 17:234,
1951. **2.** Hock, C. W.; J. M. A.
Ga. 47:154, 1951. **3.** De-
rone L.; Canad. M. A. J.
69:522, 1953. **4.** Cholat,
M.; Gondstein, S.; Ben-
yamin, G., and Cinotti, A.;
J. A. M. A. 106:1276, 1966.

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TRADEMARK: *BENTYL

Medical Economics

NEWS BRIEFS

PATIENTS YOU'VE THOUGHT UNINSURABLE because of poor medical history may not be so now, a study by this magazine indicates. Some 100 conditions that carriers used to shy away from are currently held insurable under substandard-risk policies.

IF YOU GIVE \$25 to your employes' children for Christmas, the gifts are deductible as a business expense, says a recent Tax Court ruling.

FEES FOR EMERGENCY CALLS ARE NOW GUARANTEED by the Philadelphia County (Pa.) Emergency Medical Service. If a patient doesn't pay, the service will: \$7 per late-night call, \$5 for others. But doctors are urged to try to get patients to pay, "as this is not planned as a charity service."

COLLECTING COLORED PILLS IS THE FAD NOW, a New York fashion editor coos. Most popular are "the rose fuchsia penicillin lozenges, the shocking pink hay fever fighters with white midriff bands."

NEWS BRIEFS

IF YOU HAVE TO TELL A PARENT his child must be put in a home for the mentally retarded in order to get proper therapy, you can offer one consolation: The Internal Revenue Service has ruled that every penny of the resultant costs is deductible.

ANTI-VIVISECTIONISTS ARE GOING ALL OUT for 2 new laws, warns Dr. Lester Dragstedt of the National Society for Medical Research. They want to bar Federal grants to institutions that don't abide by a complex animal-care code, and to ban interstate shipments of dogs and cats for experimental use.

FIGHT BETWEEN RIVAL BLUE SHIELD PLANS, which recently split the Wisconsin state medical society, is drawing the fire of that state's press. Says the Milwaukee Journal: "Respect for medical leadership in Wisconsin suffers severely...If the end result should be some drastic legislation to assure...public protection,...the doctors should have no reason for surprise or complaint."

JUNGLE-TYPE MEDICAL ECONOMICS is what the fee-for-service system is called in a new book for laymen, "The Doctor Business." The system is clearly "inadequate," yet organized medicine won't let it change, says Author Richard Carter. He concludes: The doctor's "need for relief from the power of organized medicine is as great as the public's."

THERE'S STILL NO NEAR-BY HOSPITAL for some 2,800,-000 Americans, says the Public Health Service. But that's better than the 1948 figure: 10,000,000.

WHEN 4 DOCTORS RECENTLY SUED the city-owned Pontiac (Mich.) General Hospital for limiting their surgical privileges, medicolegal men discovered that no Michigan law specifically empowers a city hospital to regulate professional practice within its walls. Now the Michigan State Medical Society is asking the Legislature to pass such a law. Otherwise, warns one society spokesman, "there'll be a rash of suits like this all over the state."

IF POPULATION GROWTH ISN'T CHECKED, we'll have standing room only by 2560 A.D., a new United Nations study shows. At today's increase rate, there will be 1 square yard of land per person by then.

THE KAISER PLAN WORKS SO WELL, says Steelworkers' President David McDonald, that he wants "something like it" for his 1,125,000-man union. Following up his earlier threat to withdraw from the Blue plans, he now intends to ask industry to give his workers their own hospitals, plus a health insurance plan that includes comprehensive hospital, home, and office care—probably provided by a closed-panel staff of M.D.s. Freedom of choice? "Just a lot of conversation," says McDonald.

NEWS BRIEFS

THERE ARE MORE AGED NOW, BUT FEWER ON RELIEF than in the '40s, reports the U.S. Government. Reason: They're getting old-age benefits under Social Security. Without such benefits, says the report, 1,800,000 more people over 65 would now need aid.

MEDICARE'S RECENT CHANGES ARE "NOT ACCEPTABLE," the Oklahoma State Medical Association has decided. It has withdrawn its local sponsorship of the program. Among its reasons: "The decision as to type of medical care to be rendered has been placed largely in nonmedical hands."

DIRECT FEDERAL AID TO MEDICAL SCHOOLS is "overdue," believes Dr. Lowell T. Coggeshall, president of the Association of American Medical Colleges. He recently warned that our schools "cannot possibly provide" enough new doctors unless they double their operational budgets in the next 10 years. The only feasible source of such funds, he said, is "direct Federal support."

CERTAIN U.S. BONDS ARE STILL TOPNOTCH BUYS for doctors concerned about how their estate taxes will be paid, say investment counselors. Fourteen series of these bonds are selling at as much as 10% below par. Yet all are redeemable at par in payment of estate taxes. And no capital gains tax is incurred when they're used for this purpose.



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New timed-release tablet provides:

- ...the superior decongestant and antihistaminic action of Triaminic
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- ...an expectorant to augment demulcent fluids
- ...the specific antipyretic and analgesic effect of well-tolerated APAP
- ...the prompt and prolonged activity of timed-release medication

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Dosage: One tablet in the morning, mid-afternoon, and in the evening, if needed. The tablet should be swallowed whole to preserve the timed-release action.

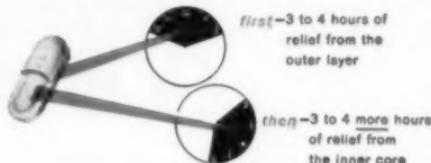
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To augment demulcent respiratory secretions.

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803001

Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, NOV. 10, 1958

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Now They Ask for Check-Ups! 75

Here's a practice builder that's actually requested by patients—if the doctor plants the idea in the right way

Delayed-Action Suits Can Land You in Court . . . 82

It's not enough to know your state's usual statutory time limit on malpractice suits. You've got to be prepared for the exceptions that can stop the legal clock for years and years. Here are five situations to watch out for

And So They Bought the Belgian Embassy 86

After eleven years in a Washington, D.C., medical office building, this group lost its lease. The building was sold, and the doctors were given thirty days to move. Practicing precariously on a month-by-month extension, they frantically searched Washington for office space. Finally, they had to act fast, so they took on this white elephant

Will Your Estate Plan Really Work Out? 92

This true account of how one doctor's errors affected his widow may help you avoid similar unfortunate mistakes

More ►

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dermatoses

Kenacort with its greater antiallergic, anti-inflammatory and antipruritic activity quickly alleviates the itching, erythema, and irritation in most inflammatory skin conditions.

The table shows the effectiveness of relatively small doses of triamcinolone (Kenacort) in the treatment of some common dermatoses.

Summary of Clinical Effects of Triamcinolone on Dermatoses in Fifty-one Patients.¹

TYPE OF LESION	HELPED, NO.	NOT HELPED, NO.
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Localized neurodermatitis	4	2
Contact dermatitis	6	6
Seborrheic dermatitis	9	0
Alopecia areata	4	1

In psoriasis, Kenacort should be reserved for those patients suffering from acute, extending or severe chronic forms of the disease. The authors report prompt and dramatic relief in 36 of 60 such patients treated with 12-16 mg. per day.

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■ with no potassium loss ^{4,5}

■ without unnatural psychic stimulation ^{1,5,6}

■ with no adverse effect on blood pressure ^{1,2,4,5,7}

■ on a lower daily dosage range ^{1,2,6,7}

1. Shelley, W.B.; Harun, J.S., and Pillsbury, D.M.: J.A.M.A. 167:959 (June 21) 1958. 2. Sherwood, H., and Cooke, R.A.: J. Allergy 28:97 (March) 1957. 3. Boland, E.W.: Geriatrics 13:190 (March) 1958. 4. Hellman, L., and others: A.M.A. J. Dis. Child. 94:437 (Oct.) 1957. 5. Hartung, E.F.: J.A.M.A. 167:973 (June 21) 1958. 6. Feinberg, S.M.; Feinberg, A.R., and Fisherman, E.W.: J.A.M.A. 167:58 (May 3) 1958. 7. Friedlaender, S., and Friedlaender, A.S.: Antibiotic Med. & Clin. Ther. 5:315 (May) 1958. 8. Dubois, E.L.: J.A.M.A. 167:1500 (July 26) 1958.

KENACORT IS A SQUIBB TRADEMARK

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Charges based on your patient's ability to pay are the fairest to both you and him, this management man contends

More ►

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Dr. Kris' \$1,500 bill for saving a boy's life stirred up the whole nation last year. Now that the hubbub has subsided, the doctor explains why he still thinks the fee was fair. 'How much would *you* charge for 100 hours spent on a case where the family's well able to pay?' he asks. Here's the side of the story that you probably haven't heard before

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With rates higher than ever, you'll want to watch your step when buying stocks. Here's how you can cut the cost

More ►

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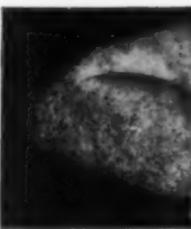
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1. Alexander, L.: Chemotherapy of depression—Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. *J.A.M.A.* 160:1019, March 1, 1958.

2. Current personal communications; in the files of Wallace Laboratories.

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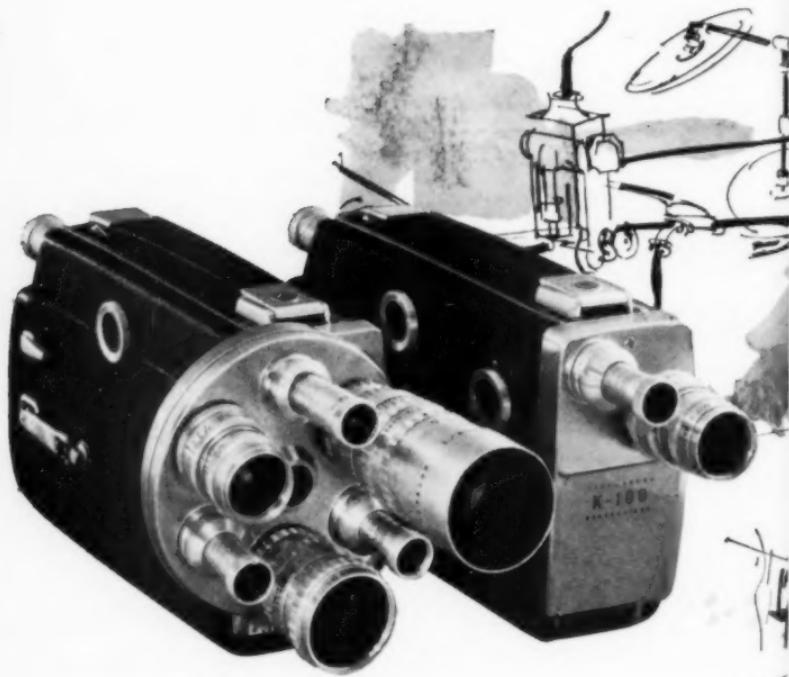
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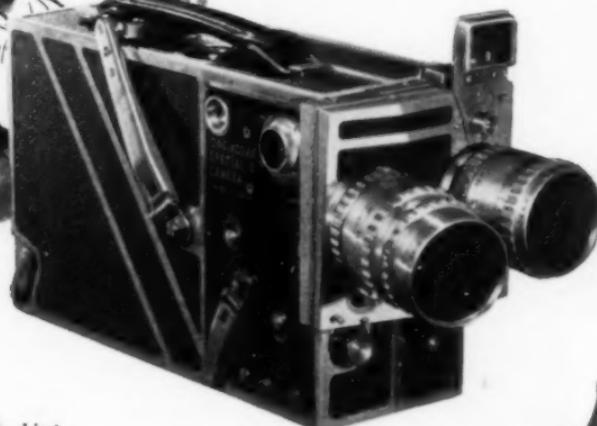
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bananas

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Letters

'Is It Serious?'

SIRS: A recent article points out the danger of unconsciously belittling yourself in the patient's eyes with "there's nothing to it" statements. When I propose surgery to a patient, I'm often asked, "Is it serious?" Before even telling him whether it's major or minor, I say something like the following: "This concerns a human being, a human life. So I take it seriously. I take every operation seriously, even if it's only removing a splinter from under a child's fingernail."

I believe such statements reassure the patient without making him feel you have a "there's nothing to it" attitude.

E. L. McPherson, M.D.
Greenville, S.C.

Podiatrists and M.D.s

SIRS: Your recent news item, "Podiatrists Get Foot in Blue Shield Doorway," implies that it's unusual for podiatrists/chiropodists to participate in Blue Shield plans.

Actually, our profession now participates in Blue Shield not only in New York but also in Calif-

ifornia, Delaware, the District of Columbia, Michigan, New Mexico, Ohio, and Oklahoma. And we're carrying on friendly negotiations with Blue Shield in several other states.

As the A.M.A. Judicial Council stated back in 1939, our profession "fairly well satisfies a gap in medical care that the [medical] profession has failed to fill."

A. Rubin, D.S.C.
Secretary, American Podiatry Assn.
Washington, D.C.

SIRS: . . . M.D.s have established podiatry-chiropody departments in some of America's leading hospitals. Among these are the Mayo Clinic, the New England Deaconess Hospital, and Walter Reed . . .

Marvin W. Shapiro, D.S.C.
Vice President, American Podiatry Assn.
Toledo, Ohio

They Started Something

SIRS: Here's a little addendum to your recent account of how Psychiatrist George Constant practices successfully in my home town:

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Letters

with Dr. Constant. Realizing that my psychiatric alertness—and, therefore, my skill as a G.P.—was being improved through my close work with a psychiatrist, I felt it would help men in both fields if we could all get to understand one another better.

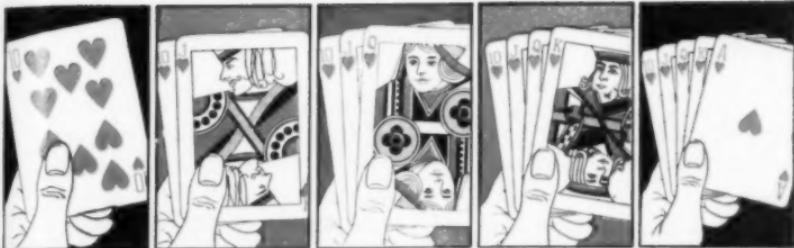
When I discussed my idea with leaders of both the American Academy of General Practice and the American Psychiatric Association, they agreed. So a liaison committee between the two societies was set up, with myself as chairman of the G.P. group, and Dr. R. A. Matthews heading the psychiatric group.

This project has advanced rapidly. Originally under a grant from the Lasker Foundation, it now has a Federal grant of \$1,300,000. And it all began because one G.P. and one psychiatrist learned they could help each other.

Andrew S. Tomb, M.D.
Victoria, Tex.

Social Security, U.S.N.

SIRS: I had to laugh at the recent letter from Capt. R. L. Fruin (M.C.), U.S.N., denouncing Social Security. Of course he doesn't need



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Pyrilamine Maleate	12.5 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Adult Dosage: one teaspoonful q. 6 h. May be habit-forming.
Federal law permits oral prescription.

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Letters

Social Security. His future is secure whether he's retired for disability or age. He isn't even taxed for it.

Lewis B. Posner, M.D.
New York, N. Y.

Plot Against Plans?

SIRS: Recent applications by Blue Cross plans for rate increases have generally been refused. Where an increase has been granted, it's been only partial—

and inadequate. The plans have been told to "spend your surplus."

Such anti-plan actions in various states betray too much similarity to be merely coincidental. There's a master design at work here, drawn by aggressive promoters of socialism. Having failed to put over by frontal attack their grand scheme for compulsory health insurance, they're now trying flank and rear-guard actions.

Here's their strategy: First, blame the doctors for alleged excess utilization of hospital benefits. Next, make the plans spend surplus

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■ notably effective ■
exceptionally well tolerated ■ the safest iron
to have in the home ■



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reserves—the lifeblood of insurance organizations. Then, when the plans approach financial disaster, let the job-seeking politicians rush in and take over. Simple, isn't it?

Make no mistake: This is part of the battle against the free and independent practice of medicine.

To each and every doctor: What are you going to do about it?

M.D., New York

Deductible Aides

SIRS: The other night, at a pow-wow of medical secretaries, someone wondered why our bosses,

who avidly read MEDICAL ECONOMICS' articles on estate building and tax savings, overlook the best tax deduction available: us!

Oh, yes—our employers all read your article last January on "How Much Do Doctors Pay Their Aides?" So they certainly know how much they can and should pay us girls.

But have they done anything about it? Oh, no.

One girl I know has been with her doctor three years. She's had only two days off because of illness. Her duties include bookkeep-

“its iron may be maintained in solution over a greater area of the gastrointestinal tract, thus permitting an optimal physiological uptake...”

“possesses outstanding qualities in terms of freedom from undesirable gastrointestinal effects.”

“The chelation of iron minimized its toxicity and provided a high factor of safety against fatal poisoning.”

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*Franklin, M., et al.: Chelate Iron Therapy, J.A.M.A. 166:1685, Apr. 5, 1958.
†U.S. Pat. 2,575,611

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At any stage of development



AMGESIC*
COLD TABLETS

- Relieves pain and headache
- Lowers fever
- Reduces nasal secretions
- Controls cough
- Combats allergic manifestations

Each Amgesic tablet contains:

N-acetyl-p-aminophenol	160 mg.
Chloropropenpyridamine Maleate	2 mg.
Noscapine	2 mg.
Levstin® (1-hyoscamine sulfate)	1/16 mg.
Aspirin	230 mg.
Caffeine	15 mg.

Supplied: Bottles of 25 and 100 tablets.

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Letters

ing, billing, making appointments, and doing blood counts, urinalyses, and electrocardiograms. No complaints from her boss. Her salary: a lofty \$57 a week, minus deductions.

We find working for these fine men rewarding in many ways. But it's understandable why so many of us have to forsake them for greener fields.

Otherwise, how could we build even a *small* estate?

Doctor's Aide, Ohio

He Serves Breakfast

SIRS: Here's something that I've found creates much goodwill in my practice: After I've given a patient a basal metabolism test, my aide brings him a breakfast tray in the test room—orange juice, buttered toast, and coffee. Appreciative patients often comment that "no doctor ever served me breakfast before."

And while the patient is eating, I can calculate the test results, see another patient or two, or even make a quick house call.

Irwin Hoffman, M.D.
Cedarhurst, N.Y.
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start with steroid therapy

For severe anorectal inflammation Anusol is now also available as *Anusol-HC* . . . hemorrhoidal suppositories with hydrocortisone.

Anusol-HC lets you *start* with steroid therapy . . . reduce and eliminate pain, heat, swelling, and hyperemia. With this simple two-stage program you can first check inflammatory symptoms safely, then *keep* patients comfortable:

1. Start with 2 *Anusol-HC Suppositories* daily for 3 to 6 days.
2. Maintain with regular *Anusol Suppositories* or *Unguent* as required.

Prescribe new Anusol-HC for safe and rapid control of harsh inflammation in hemorrhoids, proctitis and anal pruritus.

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hemorrhoidal suppositories with hydrocortisone



in diabetic retinopathy

and other eye disorders
involving capillary fault



CVP improved visual acuity
and cleared hemorrhages more rapidly

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C. V. P.—"a valuable therapeutic aid in the management of certain ocular diseases,"¹ as evidenced in a series of 89 patients suffering from various ophthalmic disorders...

diabetic retinopathy — a significant number of patients on C.V. P. "showed definite improvement in visual acuity."

idiopathic retinal hemorrhage was "favorably influenced" by C.V. P.

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... and in hypertensive retinopathy, vitreous hemorrhage, Kuhnt Junius disease, and central angiopathic retinopathy, C.V. P. proved most useful.



C.V. P. helps to correct abnormal capillary permeability, fragility and resultant bleeding by acting to thicken the "cement" substance of capillary walls. C.V. P. is exclusive and different. Provides many active water-soluble factors of the whole natural citrus bioflavonoid complex. Readily absorbed and utilized, C.V. P. is relatively free (due to special processing) of hesperidin, naringin and other comparatively insoluble and inactive flavonoids found in citrus.

Each C.V. P. capsule or teaspoonful (5 cc.) of syrup provides

CITRUS BIOFLAVONOID COMPOUND	100 mg.
ASCORBIC ACID (vitamin C)	100 mg.
bottles of 100, 500, and 1000 capsules, 4 oz., 16 oz. and gallon syrup.	

DUO-CVP (double-strength) provides per capsule 200 mg. of Citrus Bioflavonoid Compound and 200 mg. of Ascorbic Acid.

¹ Ralph, F. T., Eye, Ear, Nose and Throat Monthly, Feb. 1958.

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in depression
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p-acetamidobenzoic acid salt of 2-dimethylaminopropanoic acid

References

1. Lemere, F., and Lasater, J. H.: Am. J. Psychiat. 114:655 (Jan.) 1958.
2. Murphree, H. B., Jr., Jenney, E. H., Jr., and Pfeiffer, C. C.: 2-Dimethylaminopropanoic Acid as a Central Nervous System Stimulant. Presented before Assoc. for Research in Nervous and Mental Disease, New York, Dec. 12-14, 1957. To be published.
3. Oettinger, L., Jr.: Presented before the American Encephalographic Society Meeting, Atlantic City, June 14, 1958. To be published. Journal of Pediatrics.

Dosage:

Initially, 1 tablet (25 mg.) daily in the morning. Maintenance dose, 1 to 3 tablets; for children, 1/2 to 3 tablets. Full benefit may require two weeks or more of therapy. 'Deaner' is supplied in scored tablets containing 25 mg. of 2-dimethylaminopropanoic acid salt.

'Deaner' a totally New Molecule

has proved to be of value in the alleviation of a wide variety of emotional disturbances.¹ It is indicated in

- chronic fatigue states
- mild depression
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- migraine
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- behavior problems and learning defects in children

'Deaner' produces greater daytime energy, better ability to concentrate, and a more affable mood.² It promotes sounder sleep.² In children it enhances adaptability and lengthens attention span.²

Another



First

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Hospitals Are Urged to Raise Their Prices

Amid the hullabaloo about the high cost of hospitalization, one hospital administrator is proclaiming that hospital charges aren't high enough. They're "too low for proper and efficient service," declares Frederick Grubel, associate director of Montefiore Hospital in New York City.

To prove his point, he cites some New York salaries. In 1956, he notes, a secretary in private industry was earning an average of \$74 a week; a year later she could still get only \$61 a week in New York's voluntary hospitals. In 1957, R.N.s got \$280 a month in voluntary hospitals, \$335 in V.A. hospitals. It's not surprising, he says, that "with laudable exceptions, the quality of the available help is not the best."

And too often there's no help available at all, Grubel adds. Last April, he reports, 22 per cent of the jobs for registered nurses in greater New York were unfilled. "The real seriousness of this situation appears," he says, "when we

learn that 80 per cent of these vacancies have been open for more than six months."

What's to be done? Grubel makes two specific suggestions:

1. Raise hospital charges "approximately \$4 per in-patient day." This, he calculates, will "enable New York hospitals to offer their nurses a reasonable income and to compete on the general labor market." The \$4 hike, he believes, will also be enough to let patients "enjoy the high standards of house-keeping and dietary service they expect of a hospital."

2. Compute hospital costs so as to include adequate salary levels. "Blue Cross and other third parties," he declares, "by granting a reimbursement of the traditionally depressed cost, help perpetuate the pauperism of the voluntary hospital."

How Older Patients Alter Your Practice Pattern

As the general population grows older, what changes may you expect in the pattern of your practice? One answer can be found in a recent study by the Health In-

to curb those
sleep-disrupting
"night coughs"



that waken the whole household...

CLISTIN® EXPECTORANT

Clistin Expectorant is the only cough product containing CLISTIN Carbinoxamine Maleate—that well-accepted, potent, antihistamine. Relieves coughs of the common cold and coughs of allergic or non-allergic upper respiratory conditions.

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"anti-cough" . . .
antihistaminic . . .
completely safe
for pediatric use.

non-narcotic . . .
does not upset
the stomach . . .

tastes wonderful

NON-IRITANT
(1) Sulfa
Ara
(2) Go
An

surance Plan of Greater New York, of how its members 65 or older use their insurance. Here's what the study indicates:

1. Your burden of work will grow. H.I.P. reports that old people visit their doctors about 40 per cent more frequently than the average for all ages.

2. You'll encounter more patients who need surgery. Aged women, H.I.P. found, actually get slightly *less* surgery than the average for other adult females. But the rate for aged men is generally higher than the rate for other adult

News • News • N

males. Gastrointestinal, abdominal, and genitourinary operations add up to three-fifths of the hospitalized surgery among the aged, and to only two-fifths of the surgery for all ages combined.

3. You'll make more hospital calls. Old people visit their doctors' offices more often than young people, and they require more house calls than other adult patients. But "the outstanding characteristic of the pattern among

RELIEVE ITCHING (1) (2) DIMINISH THICKNESS OF Affected SKIN (2) REDUCE SCALE (1) (2)

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Lesions are promptly and
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(1) Sulzberger, M. B. and Obadia, J.,
Arch. Derm., 73:373 (April) 1958

(2) Goldberg, L. C., and Barnett, S. B.,
Antibiotic Med. & Clin. Therapy, 4:594 (Oct.) 1957

• News • News

the older people," says H.I.P., "is the exceptionally high proportion of [physician] visits in the hospital—21 per cent as compared with 11 per cent for all ages."

New Specialists Outnumber New G.P.s by 2 to 1

The newly issued American Medical Directory points up the surging trend toward specialism among recent graduates. There's been a gain of some 9,000 full specialists since

the 1956 edition, compared with an increase of only about 4,000 general practitioners. The U. S. totals still give general practice an edge—90,359 G.P.s to 77,655 specialists—but only because partial specialists are counted as G.P.s.

Other highlights from the directory's 1958 edition:

¶ New York's doctor-population (30,786) continues to top that of any other state.

¶ California has gained the most physicians (1,467) in the last two years. Other big gainers: Florida, Michigan, Ohio. *More* ▶



Doctor - when you prescribe steam for colds...

Recommend an automatic HanksCraft VAPORIZER



HanksCraft vaporizers have long been popular for the effective treatment of respiratory ailments. Their new, vastly improved design incorporates the latest advancements in automatic steam vaporization. Simplicity of construction assures trouble-free, completely safe performance. Gallon capacity — delivers steady flow of healthful steam all night on one filling, then shuts off automatically when water is gone. No complicated parts — easy to clean — approved by Underwriters' Laboratories.

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and so is still irritated by

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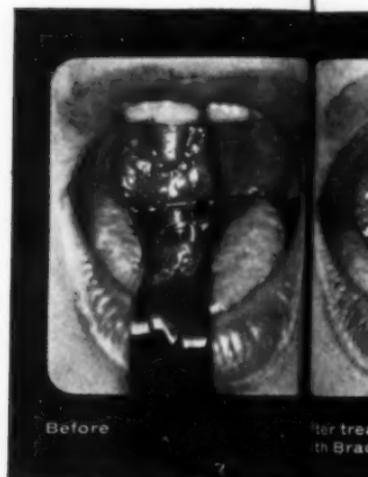
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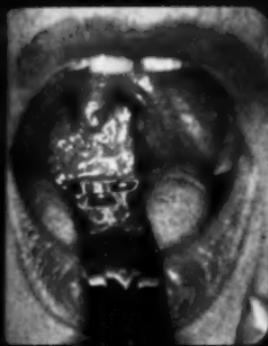
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of
sore throat
in minutes



New Bradosol

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infection
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After treatment
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**Combats oral infections... soothes
irritated tissues**

Bradosol bromide is a new quaternary ammonium antiseptic of extremely low toxicity. Clinical trials have shown that Bradosol Lozenges are highly effective in the prevention and treatment of common mouth and throat infections and irritations. "Strep. throat," tonsillitis, pharyngitis, laryngitis, oral thrush—these are representative of the conditions in which clinicians report good to excellent results. And, since Bradosol Lozenges contain an effective topical anesthetic (benzocaine), patients report *symptomatic relief* within moments.

Not antibiotic... therefore, no antibiotic side effects

Stomatitis and glossitis—commonly reported with certain antibiotic lozenges—do not occur. Resistance to Bradosol is not to be expected, nor is sensitization a clinical problem. Moreover, Bradosol Lozenges act against most, if not all, of the common invaders of the oral cavity. Even fungi, such as thrush-causing *Candida albicans*, are susceptible to Bradosol.

Supplied: Lozenges, each containing 1.5 mg. Bradosol bromide and 2.5 mg. benzocaine; packages of 24 in the convenient "Flip-Top Box."

BRADOSOL® bromide (domiphen bromide CIBA)

2/2610 RR

C I B A SUMMIT, N. J.

• News • News

"The doctor-population has declined in at least three states: Iowa, Minnesota, and Missouri.

Free Competition Good? 'Not Among Hospitals'

"No modern planner can . . . consider multiple small hospitals an asset to the community," declares Dr. Anthony J. J. Rourke, a leading hospital consultant. The notion that free competition among hospitals is healthy, he adds, is a myth.

"There is no competition in the quality of medical care," he declares. "Frequently the same Dr. Coronary treats heart disease on the same day in two or more hospitals." For the doctor, multiple facilities merely mean that his "time is dissipated in unnecessary travel."

And for the hospital, Dr. Rourke observes, "competition more often appears to me to resolve itself into pirating of personnel or duplicating of expensive equipment, in order to keep up with the Joneses." The only possible justification for this

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dip 1 strip... read 2 tests!**

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REAGENT STRIPS

colorimetric "dip-and-read" combination test
for PROTEIN and GLUCOSE in urine.

Available: Bottles of 125.



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Continuous control of gastric acidity with frequent and regular small, bland feedings, was advocated by **Bertram W. Sippy** (1866-1924) as essential in the management of peptic ulcer.

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Milpath®

® Miltown + anticholinergic
controls hypersecretion
and hypermotility,
provides relief of pain, spasm,
anxiety and tension without
belladonna or barbiturates.
Side effects are minimal.

Formula: each scored tablet contains:
meprobamate 400 mg., tridihexethyl iodide 25 mg.

Dosage: 1 tablet t.i.d. with meals and 2 tablets at bedtime.

Indications: duodenal and gastric ulcer • colitis
spastic and irritable colon • gastric hypermotility • gastritis
esophageal spasm • intestinal colic • functional
diarrhea • G. I. symptoms of anxiety states.

Literature and samples on request.



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New from Carnation



Carnation Company announces
a new ready-prepared infant formula
based on the medical preference
for evaporated milk

Carnalac is Carnation Evaporated Milk with carbohydrate and Vitamin D added. Diluted with water, Carnalac provides the typical Carnation Evaporated Milk *formula*, as usually prepared at home.

EASY TO SPECIFY—JUST ADD WATER

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NOW—2 WAYS TO SPECIFY CARNATION EVAPORATED MILK

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*for maximum
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2.
*for maximum
flexibility
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sort of thing is distance—which “with improved transportation,” Dr. Rourke argues, “is no longer a major factor.”

His conclusion: “Every effort should be made to urge independent community hospitals not operated by religious groups to merge . . . In large towns and cities, no general hospital [should] be less than 200 beds.”

Industrial Practice Said to Make Better M.D.s

Part-time industrial work can make you a better all-round physician, says Dr. E. A. Irvin, medical director of the Ford Motor Company. It enables you to evaluate patients’ ailments “in the light of both their occupational and nonoccupational activities.”

The doctor who lacks this two-sided view “might not best serve his patients, his community, and his profession,” Dr. Irvin warns. And he cites this example:

“In Detroit several years ago . . . a doctor examined his thin, ashen-faced patient—a factory spray painter—and gave a diagnosis of lead intoxication. But as it turned out, there was no lead in the factory paint; the patient actually was

suffering from a nonoccupational primary anemia.”

Such “unnecessary mistakes” are bad enough when they affect just one patient, says Dr. Irvin; but sometimes they affect a whole plant. Case in point:

“In another Midwest community, all 100 employes of a plant handling Fiberglas were on the point of walking off their jobs last fall when a woman worker showed



Irvin

up wearing a gas mask. She said her physician [had] advised that she wear [it] to protect her lungs at work. The walkout was averted when everyone was assured there were

no respiratory hazards in handling Fiberglas on this particular job.”

Such “embarrassing situations” wouldn’t arise, Dr. Irvin suggests, if the private physician didn’t “isolate himself from the bursting occupational health scene.”

Funeral Directors Want Faster Autopsies

Funeral directors aren’t entirely reconciled to autopsies as presently performed. Doctors who attended a recent Funeral Directors’

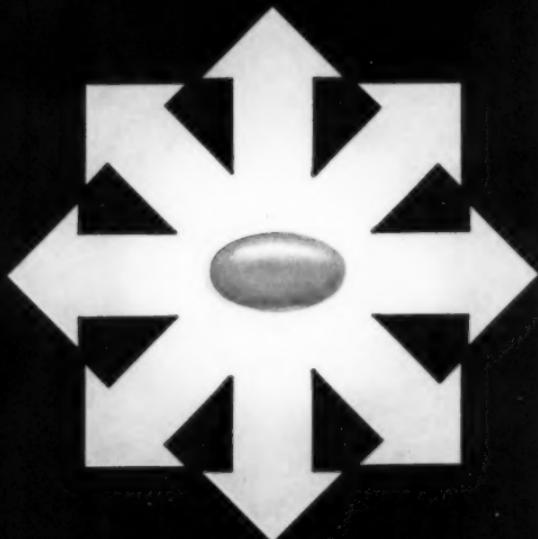
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PATIENT RECOVERY
BY MEETING
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the extended-range therapeutic vitamin-mineral tablet

Now, prescribe faster recovery for your patients . . . from teen-agers to golden-agers . . . with only one Tablet 'Mi-Cebrin T' a day.

Surgical patients,^{1,2,3} individuals suffering from febrile diseases,^{4,5} patients with severe burns or injuries,^{1,4,5} and those undergoing any prolonged convalescence—all snap back faster with potent nutritional supplementation as provided by 'Mi-Cebrin T.'

B₁₂ Absorption Booster

'Mi-Cebrin T' is especially useful in geriatrics because, along with vitamins and minerals, it provides intrinsic factor to "boost" absorption of vitamin B₁₂ in those elderly patients whose absorptive ability is impaired.^{6,7}

Each Tablet 'Mi-Cebrin T' supplies:

Thiamine Mononitrate (B ₁)	15 mg.	Vitamin A Synthetic . . . (25,000 units)	7.5 mg.
Riboflavin (B ₂)	10 mg.	Vitamin D Synthetic . . . (1,000 units)	25 mcg.
Pyridoxine Hydrochloride (B ₆)	2 mg.	Contains also	approximately
Pantothenic Acid (as Calcium Pantothenate, Racemic)	10 mg.	Iron (as Ferrous Sulfate)	15 mg.
Nicotinamide	100 mg.	Copper (as the Sulfate)	1 mg.
Vitamin B ₁₂ (Activity Equivalent)	7.5 mcg. plus sufficient Intrinsic Factor Concentrate to produce activity equivalent to that of 1/2 U.S.P. APA unit (oral)	Iodine (as Potassium Iodide)	0.15 mg.
Folic Acid	0.2 mg.	Cobalt (as the Sulfate)	0.1 mg.
Ascorbic Acid (as Sodium Ascorbate) (C)	150 mg.	Boron (as Boric Acid)	0.1 mg.
Alphatocopherol (as Alphatocopheryl Succinate) (E)	5 mg.	Manganese (as the Glycerophosphate)	1 mg.
		Magnesium (as the Oxide)	5 mg.
		Molybdenum (as Ammonium Molybdate)	0.2 mg.
		Potassium (as the Chloride)	5 mg.
		Zinc (as the Chloride)	1.5 mg.

Dosage: 1 tablet a day, or more as needed.

Available in bottles of 30, 100, and 1,000 at pharmacies everywhere.

References: 1. J. Am. Dietet. A., 30:1256, 1954. 2. Am. J. Clin. Nutrition, 3:501, 1955. 3. Ann. Surg., 140:661, 1954. 4. M. Clin. North America, 40:1473, 1956. 5. J. Oklahoma M. A., 50:333, 1957. 6. J. Am. Geriatrics Soc., 6:190 (March), 1958. 7. Am. J. Clin. Nutrition, 5:651, 1957.

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§ • News • News

Conference in Mississippi report that some of the morticians "freely admitted" trying to prevent autopsies from taking place.

According to Dr. Kenneth M. Heard of Jackson, Miss., the objection isn't to autopsies as such. "Their main concern is with *time*," he says. "They want to know particularly when the body will be available to them so that they can more intelligently discuss funeral arrangements with the family."

They also object to the fact that doctors often delay reporting autopsy findings to the family, without advance warning that there'll be a delay. Dr. Heard reports that "some funeral directors stated that actually families came to them seeking information regarding the findings."

Both these complaints are reasonable, Dr. Heard thinks; and he urges pathologists and attending physicians to remove the grounds for them. He also recommends that more doctors take the trouble to go to morticians' conventions and

whenever he starts to

he's ready for

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New vitamin-mineral supplement
in delicious chocolate-like nuggets

Each nugget contains:

Vitamin A.....	5,000 Units*	Boron.....	0.1 mg.
Vitamin D.....	1,000 Units*	Cobalt.....	0.1 mg.
Vitamin E.....	75 mg.	Fluorine.....	0.1 mg.
Vitamin E.....	3 mg. D.L.	Iodine.....	0.2 mg.
Vitamin B-1.....	2.5 mg.	Magnesium.....	0.5 mg.
Vitamin B-2.....	2.5 mg.	Manganese.....	1.0 mg.
Vitamin B-6.....	1 mg.	Molybdenum.....	1.0 mg.
Vitamin B-12 Activity.....	3 mcg.	Potassium.....	2.5 mg.
Panthene.....	5 mg.	"U.S.P." units.....	1 mg. units
Nicotinamide.....	29 mg.	Dose: One Nugget per day	
Folic Acid.....	0.1 mg.	Supplied: Boxes of 30—one	
Biotin.....	30 mcg.	month's supply or	
Putin.....	12 mg.	Boxes of 90—three	
Calcium Carbonate.....	125 mg.	months' supply or	
		family package.	



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SANDRIL* & PYRONIL† AVERTS NASAL CONGESTION



Relieves the most common side-effect of reserpine

Approximately half of all patients taking any *Rauwolfia* preparation experience the annoying side-effect of nasal stuffiness. 'Sandril' & 'Pyronil' relieves nasal congestion in about 75 percent of your patients who experience this troublesome side-effect.

*Sandril (Reserpine, Lilly) †Pyronil (Pyrrobutamine, Lilly)

Each tablet combines:

'Sandril' 0.25 mg.
'Pyronil' 7.5 mg.

Dose: Usually 1 tablet b.i.d.

Also 'Sandril': Tablets, 0.1, 0.25, and 1 mg. Elixir, 0.25 mg. per 5-cc. tea-spoonful.

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7S • News • News

explain why autopsies are important.

After this was done in Mississippi, he recalls, "several funeral directors [said] they henceforth would make no efforts to prevent the obtaining of an autopsy."

Cancer Specialists Stymied By Patients' Fears

Fear as a factor in cancer control has recently been investigated by Dr. Robert J. Samp of the University Hospitals, Madison, Wis. And he's come up with some startling figures:

"We picked out several hundred patients from our tumor clinic who'd been patients during a short period in 1956," he reports. "We learned that 30 per cent of them failed to keep their return appointments. Of these, we found that one-third hadn't even visited their own [the referring] doctor.

"The reason they didn't return was fear. Many of them admitted to premonitions and apprehensions. Some confessed they'd come to the hospital and then left before being seen, 'for fear that something might be discovered.' "

What this means, in terms of needless suffering, is spelled out

by Dr. Samp in another set of figures. "Close to 35 per cent of our patients are treated for cancer or complications of cancer *after*

the initial treatment," he reports. "In other words, a good share of a patient's important treatment comes from three months to ten years after the initial diagnosis



Samp

and treatment.

"Our failure to get these people to return," he concludes, "shows how little we know of human nature. There's an obvious need for re-evaluation of our public cancer-education effort, and of the whole field of doctor-patient communication."

Doctors Honor Sponsor Of Anti-U.M.W. Bill

Last spring, when Kentucky's Governor A. B. (Happy) Chandler was asked if he planned to veto or sign a bill aimed at forcing the United Mine Workers to guarantee free choice of physician, he shrugged his shoulders eloquently and said: "What can I do? They've got me in between the A.M.A. and John L. Lewis." More ▶

°SYRUP

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- Consider 'Histadyl E.C.' for your coughers of all ages.

Each tasty teaspoonful provides:

Codeine Phosphate	1/6 gr.
Thenylpyramine Fumarate	1/5 gr.
Ammonium Chloride	1 2/3 grs.
Ephedrine Hydrochloride	1/12 gr.

*Federal record of sale required.

*Histadyl E.C. (Thenylpyramine Compound E.C., Lilly)

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So Happy Chandler did nothing. And the bill died.

This fall, at the Kentucky State Medical Association's annual meeting, a good many doctors who'd been pushing for passage of the free-choice bill found themselves in pretty much the same position as Happy Chandler. At a time when the A.M.A. is studying the whole free-choice question, they didn't want to rush through any hastily drafted resolutions assailing John L. Lewis. But they showed where their real feelings lay when they chose one of their number for the state association's distinguished service award.

Whom did they pick for this honor? None other than the author of the free-choice-of-physician bill, Dr. Joseph E. Johnson, a general practitioner who's served in the State Legislature since 1949.

The Kentucky delegates obviously weren't ready for an immediate showdown with the U.M.W. They voted down or re-



Johnson

ferred to committee the following three proposals:

1. To "express unalterable opposition to any and all medical plans that deny the patient free choice of physician."
2. To declare ineligible for state society membership doctors who work with such plans.
3. To knock out of the state society's bylaws the two paragraphs providing appeals machinery for doctors who are denied, or suspended from, county society membership.

Beyond that, the delegates directed a special committee to study how best to get along with the United Mine Workers.

At the same time, however, they laid the groundwork for a new legislative push for free choice of physician. They voted a \$15 increase in dues, part of which will probably help pay for stepped-up legislative activity.

"We're always fighting a rear-guard action in Congress and in the State Legislature," comments Dr. Richard R. Slucher, a member of the special committee on U.M.W. relations. "If we keep on fighting rear-guard actions, we'll always be practicing third-party medicine a lot sooner than we expect."

No new legislation is possible right away. The State Legislatu-



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age dose of iron for hypochromic anemias, including nutritional deficiency types. The intrinsic factor in the 'Trinsicon' formula enhances (never inhibits) vitamin B₁₂ absorption.

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doesn't meet again until 1960. But when it does, one of the front-row senators will be the Kentucky doctors' own distinguished-service-award winner, Joseph E. Johnson. And the M.D.s all know where *he* stands.

California's Calling—If You're a G.P., That Is

Do you feel the pull of California, "the doctor magnet"? That's what the state seems to Lynne Atherton as she runs the placement service of the California Medical Association. Although she has a backlog of doctor-applicants from all over the world who want to locate in California, she'd welcome your name if you're "a good G.P."

"A general practitioner with two years of residency can be placed almost immediately," says Miss Atherton. Conversely, she says there's "an overdose of specialists" in California.

It's easy to see why she thinks so. She lists 198 board-certified and board-eligible surgeons in her files. But she's had calls for only three surgeons in six months.

Other specialists buck the same kind of odds. For instance, she has 228 internist-applicants for a mere

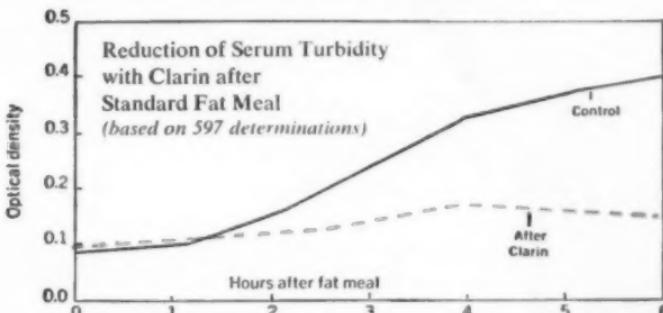
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a vitally different approach to the therapeutic concept of coronary artery disease... a tablet of heparin

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clears lipemic serum



Each time your patients eat a substantial fat-containing meal, lipemia results. Small amounts of injected heparin will help control this increased fat content in the blood,^{1,2} but widespread adoption of this method has been hampered by its inconvenience, pain, cost and the necessity for periodic checks on blood clotting time.

Now, long-term preventive heparin therapy is practical for the first time with the introduction of CLARIN — which is heparin in *sublingual* form. Each CLARIN tablet contains 1500 I. U. of heparin potassium—a sufficient amount to clear lipemic serum without affecting coagulation mechanisms.^{3,4}

With one mint-flavored CLARIN tablet under the tongue after each meal, lipemia is regularly controlled, removing a constant source of danger to the atherosclerotic patient. He may eat safely, with less fear of dangerous results, without hard-to-follow diets.

The varied implications of CLARIN in beneficially affecting fat metabolism are obviously far-reaching. The relationship between heparin, lipid metabolism and atherosclerosis may well be

analogous to that between insulin, carbohydrate metabolism and diabetes mellitus.⁵

Use CLARIN to protect your atherosclerotic patients — the postcoronaries and those with early signs of coronary artery disease.

Indication: For the management of hyperlipemia associated with atherosclerosis.

Dosage: After each meal, hold one tablet under the tongue until dissolved.

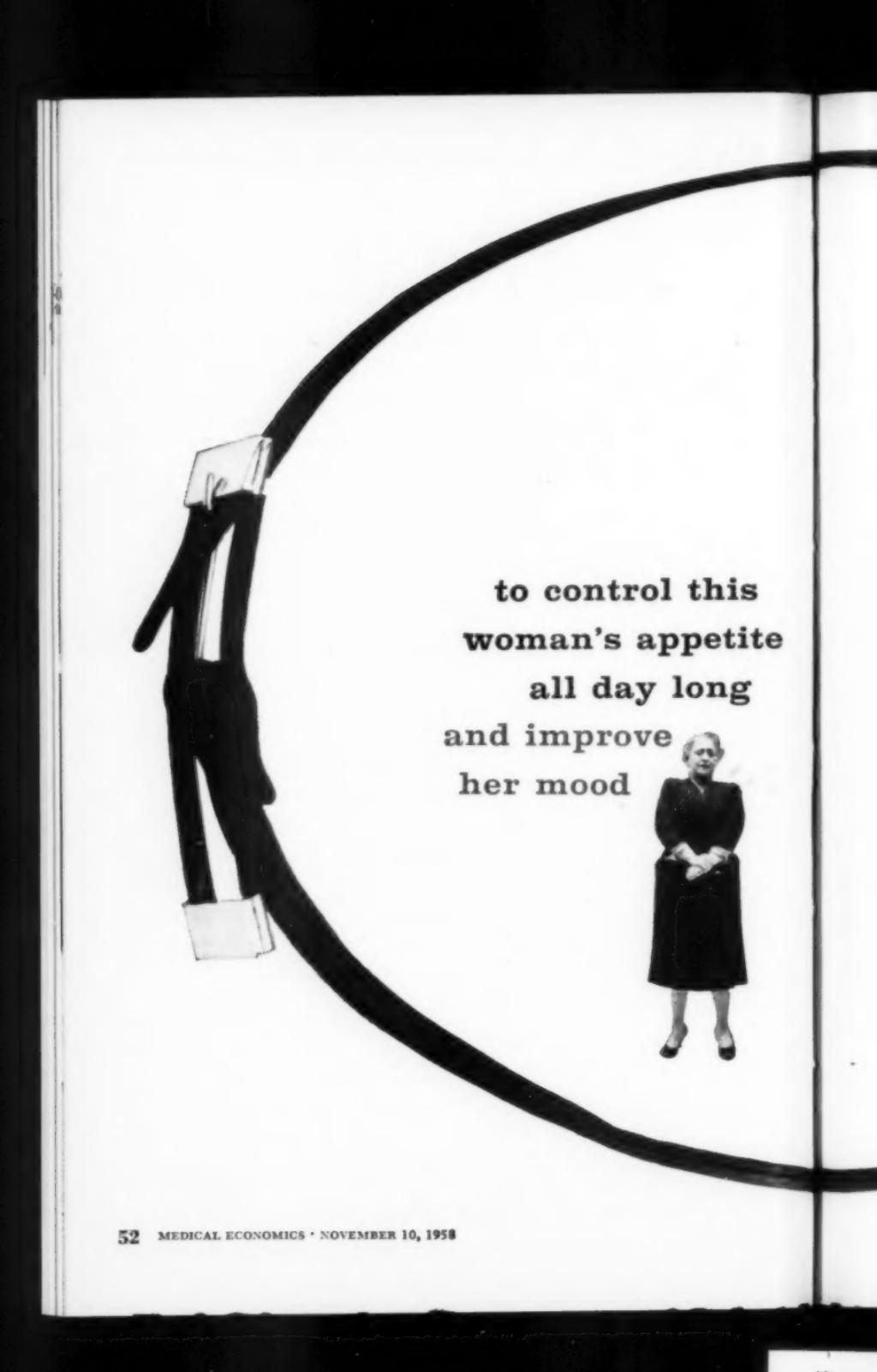
Supplied: In bottles of 50 pink, sublingual tablets, each containing 1500 I. U. heparin potassium.

1. Council on Drugs, J.A.M.A. 166:52 (Jan. 4) 1958. 2 Hahn, P. F.: Science 98:19 (July 2) 1943. 3. Fuller, H. L.: A. M. A. Scientific Exhibit, June, 1958. 4. Rubio, F. A., Jr.: Personal communication. 5. Engelberg, H., et al.: Circulation 13:489 (April) 1956.

*Trade Mark. Patent applied for.

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**to control this
woman's appetite
all day long
and improve
her mood**

DEXAMYL*

'Dexedrine' plus amobarbital

SPANSULE*

sustained release capsules, S.K.F.

In the overweight patient, a single 'Dexamyl' *Spansule* capsule taken in the morning will control appetite all day long, *at the same time* allaying the tension and anxiety which often contribute to overeating.

Because they elevate mood, as well as effectively control appetite, 'Dexamyl' *Spansule* capsules make dieting easier.

Available in two dosage strengths:

No. 2 (standard strength) and No. 1 (lower strength).

* * *

To control appetite all day long in the listless and lethargic patient who needs to be gently stimulated, prescribe

DEXEDRINE* SPANSULE*

dextro-amphetamine sulfate, S.K.F.

sustained release capsules, S.K.F.

5 mg., 10 mg. and 15 mg.

*Smith Kline & French Laboratories,
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*T.M. Reg. U.S. Pat. Off.

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four openings; twenty-eight pathologists, two openings; sixty-nine pediatricians, three openings. (One exception to the generally bleak placement prospects for specialists: Miss Atherton reports "excellent opportunities" for EENT men—twelve applicants for seven openings.)

How does the outlook for general practitioners compare? Miss Atherton estimates that it's five times easier for a G.P. to be placed than for a specialist. But she emphasizes that the desirable general practitioner is well-trained: "A G.P. without training beyond internship can be nearly as difficult to place as a surgeon."

War-Crime M.D.s Back In Practice Abroad

German doctors who experimented on concentration-camp inmates are being allowed to resume practice, in a "cynical affront to . . . the high ideals of the true practice of medicine throughout the world."

The words are those of the British Medical Association. It's been told of a woman doctor who was sentenced to twenty-five years' imprisonment at Nuremberg in 1946. She was released in 1952, received

an interest-free loan to get started again, and is practicing today in Northwest Germany.

Other practitioners linked with war crimes are getting similar favorable treatment, according to the B.M.A. It's protesting to German authorities.

State-Wide Blue Plan Tries County-by-County Rates

One of Blue Cross-Blue Shield's perennial problems is being tackled in a new way. The problem: How to give subscribers some incentive for not seeking unnecessary hospitalization under the plan. The solution on trial in Oklahoma: Adjust premiums county by county so that they reflect local utilization rates.

According to N. D. Helland, executive director of Oklahoma's Blue Cross-Blue Shield, here's the way the scheme will work:

At the end of each year, subscribers' premiums in every Oklahoma county will go either up or down. Which way they go will depend on how much the plans paid out the previous year in that county in relation to premium income there.

For example, in a county where only two-thirds of the premium income was paid out during the year, subscribers' premiums will be



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around the clock...at doses lower than other antihistamines.



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slashed 15 per cent. Where just about all the premium income was paid out, subscribers' premiums will rise 15 per cent. Where substantially more than the premium income was paid out, premiums will shoot up 30 per cent, 45 per cent, or even more, on a sliding scale.

By basing subscriber charges on the previous year's results in each county, the state-wide plan hopes to remind doctors and patients of the direct relation between utilization and price tag. The Blue Cross-Blue Shield Board of Directors approved the idea last spring. It went into effect this summer.

OB Patients Say They're Left in the Dark

How many doctors talk with prospective mothers about the details of their forthcoming confinements?

To find out, Mrs. Christine S. Smith, a Denver obstetrical nursing instructor, surveyed 250 private patients. Seventy per cent of the women said their doctors had told them nothing to prepare them for labor. The others said they had received what Mrs. Smith calls "very minimal preparation."

This question was also put to the

patients: "How did your doctor prepare you for this hospitalization?" Mrs. Smith's findings: "Half . . . had been offered no information; others were offered information regarding the hospital's and doctor's fees."

Hollywood Mourns Flop of Panel Plan for Pets

West Coast champions of private medicine chuckle when they relate what's happened to a dog-and-cat version of a closed-panel health plan. It's P.H.P.—that's right, for Pet Health Plan—and it was the talk of Southern California three years ago. It offered almost complete pet care for an annual premium of from \$25 to \$30, the care to be provided by a staff of twelve veterinarians.

Private vets in the area were worried at first, because P.H.P. started off with a bang. At its head was a former executive director of California's Blue Shield. In its bank account was \$3,000,000, put up mainly by film-star backers. The money went in many directions: to start constructing a supermodern animal-care center; to finance newspaper ads and billboard displays; to recruit veterinarians, including one who reportedly was offered a \$50,000 salary.

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in delicious chocolate-like nuggets



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tops with adults, too.

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Vitamin A 5,000 Units*
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Manganese 1.0 mg.
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Your patients should know

**THE TRUTH
ABOUT
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STOCKINGS**

*They want sheerness . . . but
you're interested in support.
There's only one way
to get both!*

*What about the new stretch
nylons that claim to be
"Support Hose"—do they
really work?*

*How can your patients be
sure they're getting all the
support you want them
to have?*





There was a time when you had trouble getting patients to wear elastic stockings because they weren't sheer enough.

Fortunately, this is no longer a problem. Today elastic stockings are made so as to be almost undetectable.

But now there's another fly in the soup . . . and this one has to do with *support*.

Specifically: the new "support hose" made *without* rubber.

The blunt fact is, these so-called "support hose" just can't do the complete job that stockings made with rubber do.

Why?

No substitute for rubber

An elastic stocking works by the elasticity of rubber (the way a rubber band stretches and contracts . . . or a rubber ball bounces).

In much the same way, the rubber in real elastic stockings "bounces back" to give necessary support. Only rubber offers this continuing return-action.

But "support hose" contain no rubber. Sure, they stretch . . . but they keep right on stretching like the stretch nylons they are.

The only true support

Your patients can get the kind of support you want them to have only with the *elastic* kind of elastic stockings . . . made with rubber.

So next time you prescribe "elastic stockings," explain the *difference* that the rubber in real elastic stockings makes.

Bauer & Black, the world's largest maker, offers a complete range of styles—for work, for informal living, or for dress-up occasions (*as sheer as 51 gauge*). And each is truly elastic . . . with rubber in every supporting thread.

Prices start at \$6.90 a pair . . . and expert fitting is available at all leading drug, department and surgical supply stores.

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Despite this glamorous start, P.H.P. somehow never got rolling. It was able to sign up only about 1,000 subscribers. So the speculating movie stars had to settle for a tax loss.

The supermodern veterinary hospital still stands unfinished—the San Fernando Valley's steel-and-glass memorial to panel medicine for pets.

Surgeon Urges Insurance For Psychoneurotics

Not just psychiatrists, but *all* doctors are personally involved in the struggle to provide health insurance for psychiatric patients. This is the contention of Dr. William E. DeMuth Jr., a surgeon in Carlisle, Pa.

He personally feels involved, Dr. DeMuth says, because he's sick and tired of seeing unnecessary surgery performed on patients who actually are in need of psychiatric care.

"I have seen one patient who had been subjected to seven hospitalizations and four abdominal operations before a competent psychiatrist was consulted," he recalls. "A serious anxiety state on the basis of a deviation in sexual behavior

was readily found . . . The expense of the last two operations was completely covered by an insurance facility which limited coverage to ten days for psychiatric diagnosis."

This and similar cases, Dr. DeMuth asserts, are caused directly by the fact that patients are usually not insured against psychoneurotic disorders. For strictly financial reasons, they and their families bring "great pressure" to bear on the surgeon.

Here, he explains, is what happens when a surgeon gets a patient who ought to have been sent to a psychiatrist:

"At least a week has been consumed to rule out organic disease . . . [before] the practitioner begins to suspect the functional nature of the disorder. He realizes that the expensive work-up may not be covered by insurance . . . The family becomes aware that not only future expense but the past expense as well may have to be borne by them . . .

"At this point, often at the patient's insistence, a bevy of consultants come into the picture . . . [Sometimes] the quest will lead to a lesion of very dubious importance . . .

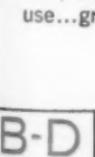
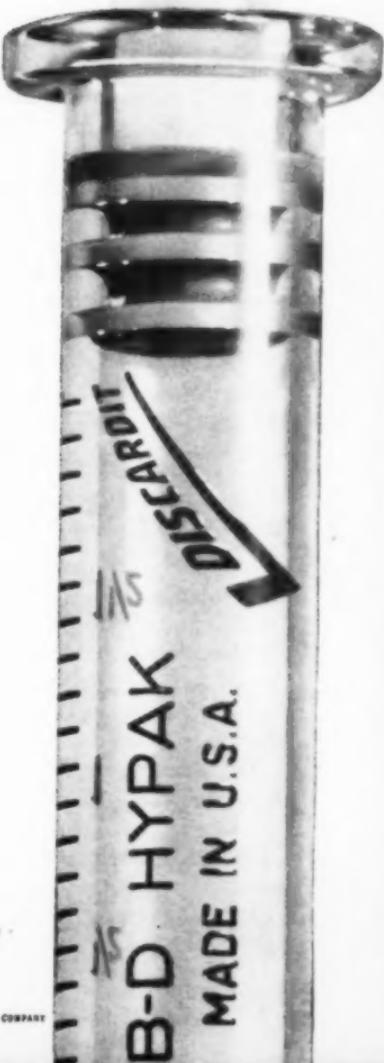
"The visceroptosis, more popular in years gone by, has been largely replaced by the small hiatal her-

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nia . . . the retroverted uterus, the small myomatous uterus, the 'chronic' appendix, and other borderline lesions which often can scarcely be fitted into the symptomatology by even tenuous reasoning . . . [This is often] the beginning of a recurring series of similar episodes which may occasionally lead to a catastrophic outcome."

Dr. DeMuth believes in leaving psychiatric problems to psychiatrists. "Until reasonable coverage is furnished," he warns, "the internist and surgeon will too often be called upon to . . . fill a gap in medical care for which they are unsuited by training or experience."

One Woman Doctor's Design for Living

Marriages have foundered over a woman's determination to practice medicine and still be a wife and mother. Here's a marriage that hasn't, because the woman M.D. has turned the usual pattern upside down:

Dr. Margaret Maynard, a Knoxville, Tenn., dermatologist, is the family breadwinner. It's her husband who manages the household.

Dr. Maynard is married to

Leonhard Scheuermann, a retired mechanical engineer. He shops for the groceries, plans and prepares the meals, supervises the housework, cultivates the garden, and looks after the children.

"It isn't usual," Dr. Maynard agrees, "but it works!"

Witch Doctors Profit From M.D.'s Example

For thousands of African witch doctors, the advent of Western civilization has been just the stimulus they needed to rise to new heights of prosperity and influence. And while they still scorn the white doctor's methods, they've benefited from his professional example.

Thus, for instance, the witch doctors are now organized into medical societies. The one in South Africa has some 4,000 members. It charges an entrance fee of \$7 and an annual membership fee of \$2.80. It enforces a code of ethics designed to encourage high standards of professional conduct.

Again, jungle medicine can now be studied at a regular "medical school; and the witch doctors hope to set up a second school. The ancient apprenticeship system is outmoded, explained one medicine man recently. It has to go, he said.

proven effective
and unusually
well tolerated
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■ does not impair mental efficiency or physical performance ■ relieves both mental and muscular tension ■ does not affect autonomic function

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now a simple office procedure



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Your patient swallows a liquid instead of a tube
— and the results are just as accurate

- eliminates discomfort and inconvenience of intubation
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- requires no special equipment
- well-tolerated and completely safe

Diagnex Blue is easy to use:

1. The patient takes DIAGNEX BLUE orally.
2. Urine samples are collected and returned to the physician.
3. Simple color comparison indicates gastric acid status.

Results are easily interpreted:

Free gastric acid is shown by color equal to or more intense than 0.6 mg. standard.

Absence of free gastric acid is shown by color equal to or less intense than the 0.3 mg. standard.

Borderline secretion is indicated by a color intermediate to these two standards.

² Diagnex Blue has been used in thousands of gastric analyses with conclusive evidence of accurate results (95% accurate identification of acid secretors, 97% accuracy in identifying achlorhydrics).

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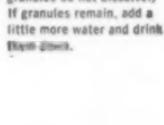
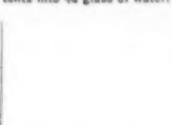
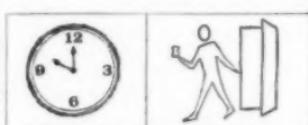
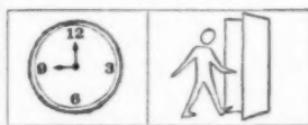
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the Priceless Ingredi-*

¹Diagnex® is a Squibb trademark.

how to perform the Diagnex Blue Test

This is what the physician tells the patient:

Start test immediately on arising, without eating or drinking anything for breakfast.



Test Procedure

Each box of DIAGNEX BLUE has a color comparator block with two color standards—one representing color intensity of 0.6 mg. azure A, and the other 0.3 mg. azure A. Color comparison should be made against a suitable light source.

- A. 1. Dilute the control and test urines with water to 300 cc. each.
2. Fill two test tubes with approximately 10 cc. of control urine each, and fill a third test tube with about 10 cc. of the test urine.
3. Place the test urine tube in the middle slot of the comparator and the control urine tubes in front of the two color standards.
4. If the color intensity of the test urine is equal to or exceeds that of the 0.6 mg. standard, the patient has secreted free gastric hydrochloric acid and the test is complete.

- B. 1. If the test sample color is less intense in color

than the 0.6 mg. standard, acidify all samples with 2 drops of diluted (10%) hydrochloric acid. Heat the three test tubes in a boiling bath for 10 minutes. (Boiling may decolor sample, but color will reappear on cooling.) Remove tubes from the bath and allow to cool for 2 hours. Compare color intensity as in A3 and A4.

2. When the color of the test specimen falls between the 0.6 mg. and the 0.3 mg. standards, this is presumptive evidence of hypochlorhydria. When the color of the test specimen is less intense than that of the 0.3 mg. standard, this is presumptive evidence of achlorhydria.

Supply. Boxes of 5 and 50 test units with comparators. Each test unit contains 2 Gm. DIAGNEX BLUE granules, two 250 mg. tablets of caffeine sodium benzoate to stimulate gastric secretion, and labels for urine samples. Complete instructions for use are included in each package.

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Gentlemen: Please send a copy of your technical leaflet,
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Address _____

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because under it the instruction is not uniform, and this is detrimental to the profession.

Even the local M.D.s have mellowed considerably in their attitude toward witch doctors. Some physicians have cultivated the medicine men, in hope of learning the source of their herbal Rx's. But so far such efforts have been rebuffed, because the witch doctors believe that once they reveal their secrets they lose the power to cure.

Yet in the care of patients, witch doctors and M.D.s sometimes work well together. One Johannesburg physician reported that in his own practice, "I found that when an operation was recommended, the African patient would leave the hospital to consult his witch doctor. If the witch doctor agreed the operation was necessary, the patient returned psychologically prepared for it."

His suggestion: "It might be time to discuss seriously the appointment of a resident witch doctor" in nonwhite hospitals. END

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NONBARBITURATE (ETHCHLORVYNOL, ABBOTT)

nudges your patient to sleep

when nausea and vomiting
bring a plea for help . . .

suggest first aid with . . .

EMETROL®

[PHOSPHORATED CARBOHYDRATE SOLUTION]

a safe, pleasant-tasting, oral antiemetic . . .

effective in 6 out of 7 cases of functional vomiting¹—often associated with intestinal "flu" or G.I. gripe. Rapidly effective . . . economical . . . and safe physiologic action usually eliminates need for potentially hazardous antiemetic drugs. Also established for safe relief of "morning sickness."²

Dose: children, 1 or 2 tsp.; adults, 1 or 2 tbsp.; repeat every 15 minutes until vomiting ceases. In bottles of 3 and 16 fl.oz. DO NOT DILUTE.

¹ Bradley, J. E., et al.: J. Pediat. 38:41, 1951. ² Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953.

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REMARKABLE LACK OF SIDE EFFECTS

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Major advance in therapy for
SINUSITIS
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**ALL DAY...ALL NIGHT RELIEF WITH A
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WITHOUT the drowsiness, dizziness or G-I disturbances
typical of antihistamine therapy

- *Keeps heads clear 10-12 hours
- *Stops the cycle of post-nasal drip
- *Provides controlled, even absorption



2 CONVENIENT DOSE FORMS...BOTH DURABONDED*

Each tabule contains:

Phenylephrine Tannate	25.0 mg.
Prophenvyramine Tannate	37.5 mg.
Pyrilamine Tannate	37.5 mg.

TABULES: Usually 1 or 2 tabules each 12 hours.

SUSPENSION (PEDIATRIC):

Children: Six years and older, 1 to 2 teaspoonsfuls
each 12 hours; under six years, according to age.
Dosage may be increased or decreased as required.

*A Durabond Process—Neisler Exclusive. Patent Pending.

Write for Literature and Samples.

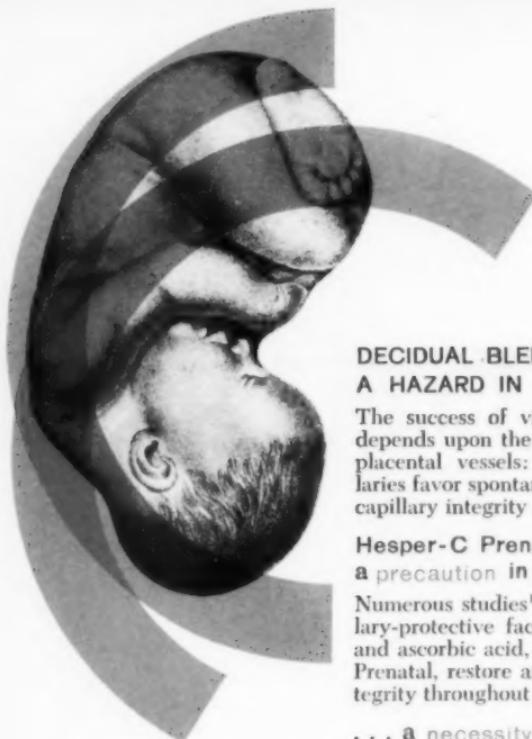
Suspension (Pediatric)—each 5 cc. contains:
Phenylephrine Tannate 5.0 mg.
Prophenvyramine Tannate 12.5 mg.
Pyrilamine Tannate 12.5 mg.

SUPPLY:

Tabules: Bottles of 30 and 500.
Suspension: Bottles of 70 cc. and one pint.

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A HAZARD IN EVERY PREGNANCY

The success of virtually every pregnancy depends upon the integrity of the mother's placental vessels. Fragile decidual capillaries favor spontaneous abortion;^{1,2} restored capillary integrity can prevent it.

Hesper-C Prenatal . . .

a precaution in every pregnancy

Numerous studies¹⁻⁶ confirm that the capillary-protective factors, hesperidin complex and ascorbic acid, as provided in Hesper-C Prenatal, restore and maintain capillary integrity throughout pregnancy.

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References: 1. Greenblatt, R. B.: *Obst. & Gynec.* 2:530, 1953. 2. Pearse, H. A., and Trisler, J. D.: *Clin. Med.* 4:1081, 1957. 3. Javert, C. T.: *Spontaneous and Habitual Abortion*, New York, The Blakiston Division, McGraw-Hill Book Co., Inc., 1957, p. 338 ff. 4. Javert, C. T.: *Obst. & Gynec.* 3:420, 1954. 5. Dill, L. V.: *M. Ann. District of Columbia* 23:667, 1954. 6. Greenblatt, R. B.: *Ann. New York Acad. Sc.* 61:713, 1955.

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Medical Economics

INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, NOV. 10, 1958

NOW
THEY
ASK FOR CHECK-UPS!



*Here's a practice builder that's required
by medical conscience and requested by patients—if
the doctor plants the idea this way*

By Leonard Casser, M.D.

If you're as squeamish as I am about "selling" even a sick patient on all the tests and examinations he ideally ought to have, how do you go about "selling" something that's going to take his money when he's well—the periodic check-up?

This problem of how to recommend preventive examinations (sometimes to a patient still paying off a bill for past medical services) used to rub so painfully on my ethical nerve that I tried dodging it. To be sure, *that*

NOW THEY ASK FOR CHECK-UPS!

wasn't exactly ideal either. Any physician hates to remember the cases he came upon too late—say, a rectal cancer developing from a polyp—that could have been caught if the patient had been given an early physical examination.

Then one day, as I was doing my house calls, a man who had just had two illnesses in his fam-

ily asked me: "Dr. Casser, just how often should people have check-ups?"

"Oh, about once a year," I said—and perhaps something in the offhand tone of my answer failed to satisfy him. Anyway, the puzzled look on his face started *me* puzzling, too:

Here was a man asking about preventive care for a family en-



"Well, Dr. Rudnic! I take it this isn't a *professional* call."

compassing every category from 2-year-old son to grandmother. And here I was recommending automatic yearly check-ups for all of them. It just didn't make sense.

It Depends on Age

The 2-year-old needed more frequent check-ups; the teenagers, less frequent. Then I began thinking about variations beyond that: the pelvic examinations women ought to have at a stepped-up pace from age 35 to 55 . . . the recurring chest and rectal examinations for mature males . . .

By now I saw what I had gotten into. I certainly wasn't looking forward to the next patient who would ask, "Doctor, how often . . .?" Answering him adequately would take up a lot of consultation time. Shouldn't I try to reduce it all to black and white—a kind of timetable of preventive care?

Comprehensive Schedule

So I rounded up a dozen lists of recommended examinations. The lists reflected the interests of a dozen different societies, each devoted to one sex or special age group, disease or diagnostic

study. I combined them in a master list of my own (see pages 78, 79, 80).

Any physician looking at my list can think of his own modifications. And perhaps he wonders: Just how can handing out such a list achieve more complete care for patients, without arousing suspicion that the doctor is "hard-selling" his services?

The simplest answer is: *Don't* hand out the list, at least not at first. Mimeograph it and place some copies on a table in your waiting room. Then see what happens.

Patients Want Them

Will they gather dust as old National Geographics used to? Quite the contrary, if my experience is any guide.

Often in my consultation room nowadays, a patient produces a copy of the list. He unfolds it and stares at me somewhat accusingly. Then he asks: "How come you haven't told me about this, Doctor? It says right here that in my age group . . ."

I've learned to welcome this implication of neglect. The patient is thinking to himself: "Here's something I ought to have, and I had to discover it for

NOW THEY ASK FOR CHECK-UPS!

myself—the doctor didn't even mention it." This gives me the chance to "sell" preventive care without seeming to pressure him into it.

The patient's attitude is quite

right, I tell him. And if he decides he wants such-and-such examinations, I add, he can leave the list with my receptionist on his way out. She will gladly work out appointments for the indicated

Minimum Health Examination

(For the best possible medical care, the patient should request his physician to schedule the following procedures at appropriate ages.)

Age	Recommendations	Age
1 or less	<i>Physical examinations; monthly weighings and feeding instructions; immunizations against diphtheria, pertussis, poliomyelitis, smallpox, tetanus; tuberculin patch test</i>	30
2	<i>Boosters against diphtheria, pertussis, tetanus</i>	35
3	<i>Hemoglobin; red blood cell count; urinalysis</i>	30-35
4	<i>Complete physical examination</i>	35-55
5	<i>Boosters against diphtheria, pertussis, smallpox, tetanus; tuberculin patch test</i>	55
7	<i>Complete physical examination</i>	40
9	<i>Hemoglobin; red blood cell count; white blood cell count; differential; urine chemistry and microscopic examination; sedimentation rate</i>	40-70
11	<i>Complete physical examination; booster against tetanus</i>	45-
15	<i>Complete physical examination; boosters against smallpox and tetanus; complete blood count; urinalysis</i>	

examinations. And later she'll mail him a reminder.

If you've spotted a loophole in this system, I agree: It gives no guarantee that every patient sees the list, or that the people who

most need check-ups mention them to you.

You may want to consider a slightly more complicated variation that I've been following recently. It's more work for the

Health-Service Prevention Recommendations

Age	Recommendations
20	<i>Complete physical examination; booster against tetanus; complete blood count; serology; urinalysis</i>
25	<i>Complete physical examination; complete blood count; urinalysis</i>
30	<i>Complete physical examination; complete blood count; urinalysis; sedimentation rate</i>
30-35	<i>Females: pelvic exam recommended yearly</i>
35	<i>Complete physical examination; complete blood count; serology; urinalysis; sedimentation rate</i>
35-55	<i>Females: pelvic examinations, including Pap-anicolaou cancer smears, recommended every six months</i>
40	<i>Complete physical examination; complete blood count; serology; urinalysis; sedimentation rate; gallbladder X-ray</i>
40-70	<i>Males: chest X-rays, rectal examinations, recommended yearly</i>
45 -	<i>Complete physical examination; complete blood count; serology; urinalysis; sedimentation rate; stool examination; basal metabolism test; electrocardiogram; chest and stomach X-rays</i>

More ►

NOW THEY ASK FOR CHECK-UPS!

doctor, but it assures him that everyone gets the information.

When I'm about to discharge a patient, I take a copy of the list from my desk and say something like:

"You're in fine shape now and of course you want to stay that

way. You may be interested in knowing the latest recommendations for routine check-ups at your age. Some of them I could do here; a few we'd have to have done in a laboratory or by a specialist."

As I talk, I underline the ap-

HEALTH EXAM RECOMMENDATIONS (Cont.)

Age	Recommendations
45-65	<i>Complete physical examination recommended every two years</i>
50-100	<i>Complete blood count, urinalysis, sedimentation rate, recommended every five years</i>
50-100	<i>Barium enema X-ray and sigmoidoscopic examination, recommended every fifteen years</i>
55	<i>Repeat procedures recommended for age 45 (above)</i>
65	<i>Repeat procedures recommended for age 45 (above)</i>
65-100	<i>Complete physical examination recommended yearly</i>
70-100	<i>Males: chest X-rays, rectal examinations, recommended every six months</i>
75	<i>Repeat procedures recommended for age 45 (above)</i>
85	<i>Repeat procedures recommended for age 45 (above)</i>
95	<i>Repeat procedures recommended for age 45 (above)</i>

LEONARD CASSER, M.D.

propriate examinations on the list. Then I hand it to the patient and, just as in the previous plan, I invite him to leave it with the receptionist.

By either method the patient walks out completely "unpressured." It's up to him whether he asks the receptionist to put his name in our reminder file. But about 90 per cent of my patients do; they seem to appreciate the suggestion.

What next? Well, when it's time to remind the patient, he gets a simple form in the mail. It says:

"Mr Jones: Complying with your request to remind you to have the following: [type of examination], I am reserving [date and hour]. If you cannot keep this appointment, kindly notify me."

It's More Trouble

This system is definitely no work-saver or corner-cutter. My aide and I put in extra hours now that may or may not be compensated by extra income. Yet sending these reminders, making arrangements with specialists and laboratories, reserving outside-office-hours time to do those examinations that fall within my

province—all this extra work is balanced by one unique compensation:

Thanks to those simple lists, I'm filling the role the public expects a general practitioner to fill: coordinator of all family medical services.

And for specialists, it seems to me such a list could be equally helpful. It could remind a patient that regardless of what specific problem brought him to the specialist, his health in general was a cause for the specialist's concern too.

Possibly my list implies extra revenue to the physician. Yet to date not a single patient has raised his eyebrows over that implication.

Only One Criticism

There's one complaint I *did* get. It wasn't that I was bidding for fees, but rather that I didn't anticipate enough of them. The gripe came from a spry gentleman of 91. He studied the list, then looked up at me.

"You call it preventive medicine," he said, "but I notice the tests you've recommended don't continue beyond age 100. You're not very optimistic about my future, are you?"

END

THESE DELAYED-ACTION SUITS CAN

It's not enough to know your state's usual statutory time limit on malpractice suits. You've got to be prepared for the exceptions that can stop the legal clock for years and years. Here are five situations to watch out for



A few months ago, the U.S. Government lost a malpractice case on the basis of a diagnosis an Army doctor had made way back in 1949.

Ordinarily, such suits against the Government are barred after two years. (Every state also has a statute of limitations to protect citizens from stale or fraudulent suits brought after long lapses of time.) Why, then, was this specific suit allowed?

Because the patient hadn't been *aware* that he had grounds for a claim until after the statutory time limit was up. He'd discovered he had TB quite some time after the



CAN LAND YOU IN COURT

By John R. Lindsey

physician—who'd apparently misread an X-ray report—had told him there was nothing wrong with him.

In the final ruling on the case, the court pointed out that the plaintiff obviously had no cause for action until he knew he'd been hurt. Thus, it said, the statute of limitations didn't begin to run from the date of the doctor's malpractice, but from the date of the patient's discovery that he was ill.

That's not a new principle. Though the statutes in most jurisdictions begin to run from the time of the negligent act, some sort of post-discovery law does hold in several states (e.g., Alabama, California, Colorado, Louisiana, Maryland, Missouri, and North Dakota).

And the 1958 decision against the Government points up a growing tendency on the part of the judiciary to treat patients' claims sympathetically, if they seem sincere.

Furthermore, the law in many states is still pretty vague about certain aspects of the statute of limitations. It's con-

DELAYED-ACTION SUITS

stantly being subjected to legislative changes and to new interpretation in the courts. For example, take California: There the question of when the statute started to run in a given case is left to the jury to decide.

So you can't always bank on the usual time limits that your state sets to protect you from suit.

That's why cautious doctors get legal advice before they sue to collect old bills. As you know, such action sometimes tempts the disgruntled patient to start a suit of his own. And the wise doctor also talks it over with his lawyer before he removes apparently outdated records from his files.

The time limit for filing malpractice suits may be a year, two years, or even six years in your state. But it's always possible that there are important exceptions to the rule—exceptions that can stop the clock for a good many additional years.

Let's take a look at the five most common such exceptions:

I. If the patient is a child, the statute of limitations may not begin to apply until he comes of legal age.

Suppose, for example, that just last week you were negligent in setting a fracture in a 5-year-old boy. If you practice in Kentucky, say, you won't be immune to a malpractice action until late in 1975—one year after the patient turns 21. And if you practice in Wisconsin, where there's a six-year statutory time limit, you won't be safe until 1980! So you'd have to hold onto your records of the case at least that long.

Such long-delayed suits are by no means uncommon. For instance, consider the current plight of one New York obstetrician: He's being sued by a baby he delivered way back in June, 1937.

The plaintiff, now 21, has named the doctor as a co-defendant in a \$300,000 suit against a hospital. As an infant, the man charges, he lost the sight of one eye through negligent application of a silver nitrate solution.

Why has he waited till now to sue? His lawyers explain that it has only recently become possible to sue New York hospitals for negligence in medical cases. As attending physician, the OB man is included in the action.

2. If the doctor deliberately conceals an injury caused by his treatment, the statute may not begin to run until the patient discovers the injury.

Courts in some states consider such concealment on the doctor's part a fraud. They hold that the fraud itself is part of the act of malpractice. But they insist that *intent to deceive* must be proved.

Two recent West Virginia court decisions illustrate the point:

In one case, it was established that the surgeon knew he had sewed up a sponge in a patient but had concealed the fact until after the one-year statute of limitations had run out. Because fraud was proved, the court allowed the patient to proceed with her action against the surgeon after seven years.

In contrast, the West Virginia Supreme Court recently barred a similar postponed suit for the following reason: Though the surgeon had left a hemostat in the patient's abdomen, there was no evidence of "actual knowledge, fraud, or concealment, on his part."

So, since the patient hadn't

brought suit within a year of the operation, she'd lost her legal right to do so.

3. Even if there's no deliberate concealment of negligence, the statute may not start to run until the patient has discovered the injury—or should have done so, using common sense.

This exception is known as the "discovery doctrine." And, as I've already pointed out, it applies in at least a handful of states. Their courts hold—as in the Federal case mentioned earlier—that some patients can't justifiably be penalized for discovering injuries after the statutory time limit has run out.

Suppose, for example, a physician unknowingly leaves part of a broken hypodermic needle in the patient's skin. And suppose the patient doesn't find out about it until after the statutory time limit is up. He can then start suit, even though there's no question of fraud on the part of the doctor.

Naturally—and luckily for medical men—the plaintiffs in such actions are generally required to prove their stories. And they don't [More on 286]

After eleven years in a Washington, D. C., medical office building, this group lost its lease. The building was sold, and the doctors were given thirty days to move. Practicing precariously on a month-by-month extension, they frantically searched Washington for office space. 'Finally, we felt we had to do something fast,' says the group's head . . .

AND SO THEY BOUGHT THE BELGIAN EMBASSY

What do you do if you have to move a large medical practice to a mansion that was built primarily for diplomatic social functions? You make the best of what you've got, of course. The photographs on these pages show

how Dr. Wallace Yater and the other members of the Yater Clinic have adapted a handsome old embassy building to their medical needs. The comments that accompany each picture tell the story as Dr. Yater recalls it.



Dr. Yater looks pretty happy here, doesn't he? But he was anything but happy when the building where his group rented office space was sold—and he learned that their lease had no option to renew. The thirteen-man group was in danger of being flung onto the sidewalk in crowded Washington. That's what almost happened. They were given notice to move, and there wasn't a vacant medical office big enough to house the clinic. Furthermore, they didn't have time to build. Their only hope was to find some sort of place they could remodel.

More ►

THEY BOUGHT THE BELGIAN EMBASSY



When the doctor's wife said she'd been shown through the empty Belgian Embassy building on Massachusetts Avenue (the Belgians have a new place now), Dr. Yater thought it sounded like a possible home for the group. Although the other doctors were less than lukewarm, he went around to take a look. He discovered that the Embassy was big enough. And it was certainly as solid as the Pyramid of Cheops. But when he inquired about financing it, nobody wanted to give the clinic a loan. "It's a one-purpose building," they said. "It would be no good for anything except an Ambassador's residence."



Dr. Yater visualized those brass letters the first day he saw the building. But before they were put up, the purchase had to be cleared through Brussels. The clinic had to raise cash. It had to remodel the interior. And there were no blueprints to go by—at least not in America. The workmen had to tear up floors and knock holes in the plaster to find pipes and wires . . . The doctors still don't know what their taxes will be. (Embassy property is tax-exempt.)



Wherever they could, the doctors tried to preserve the building's grandeur. The Ambassador's library, for instance, made the transition to a medical library with ease—but it still looks quite grand. But some of the other changes were pretty expensive. It cost \$450 just to have one pair of big wrought-iron doors rehung in accordance with current building code specifications.



Not many years ago the belles of all nations trailed down this wide stairway. But they couldn't hold onto that utilitarian handrail you'll notice against the wall. The doctors put it in as an aid to patients taking the inside lane. Besides, it isn't easy to get a firm grasp on the carved oak balustrade. More ►

THEY BOUGHT THE BELGIAN EMBASSY



The butler's pantry, where the Ambassador's Sèvres and Limoges used to be kept, is now used for storing lab equipment.



The dumb-waiter that once carried breakfast trays up to resident dignitaries has become useful as a means of sending medical records and X-ray films from floor to floor. The girls wear gloves so they won't get rope burns.

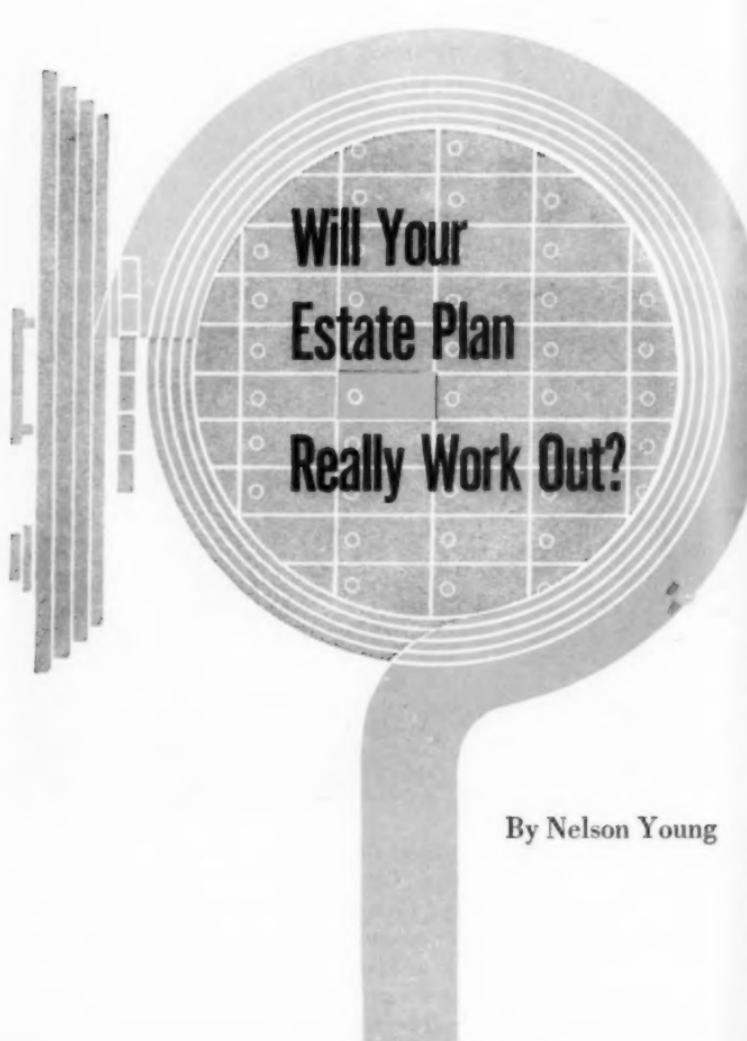


Some of the changes were really radical. This small minor-surgery room was once the Ambassador's bathroom. And the stately ballroom and banquet hall on the second floor were partitioned off into small offices and examining rooms. The doctors had to lower their sixteen-foot ceilings, to keep them from seeming like empty elevator shafts.



When the remodeling job was finished, the Yater Clinic had a total of sixty-one rooms. Up on the top floor is a big, rambling space where the doctors can gather for conferences and coffee breaks. In this photo, you can see some of the comforts and conveniences. The nurses and aides have a similar room . . . "Well, the whole thing has been quite a project," says Dr. Yater. "But now that we're settled in, we think we're just about the best-housed medical group in the country."

END



By Nelson Young

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This true account of how one doctor's errors affected his widow may help you avoid similar mistakes

Dr. Charles Barnes was a confirmed do-it-yourself fan. He designed his home, his den furniture, his outdoor patio. All such projects turned out successfully. Then he tried his hand at designing an estate plan.

It was the one do-it-yourself job he shouldn't have tackled. The fact that he'd bungled it became tragically apparent at his premature death early this year. His widow and four young children will feel the effects for years to come.

They're not penniless. But Mrs. Barnes will eventually have to take up professional nursing again. The children may not be able to get through college. And there'll be tight budgeting every step of the way.

How did it happen? What mistakes did Dr. Barnes make? Since his errors might well serve as an object lesson for any young doctor with a family, let me tell you the story from the beginning.

In 1954, the doctor asked me to do a complete survey of his professional and personal finances. "I'd like to know exactly where I stand today," he explained. "Then I'll have a sound basis on which to plan for the future."

So I did what he asked. My findings in the three major categories of income, investments, and insurance were as follows:

INCOME: Since 1951, Dr. Barnes had practiced as a board-certified pathologist in a medium-size hospital. His income had now reached a plateau. In any one year, it was pretty sure to amount to around \$24,000 after taxes.

That seemed about right for his volume of practice. And his earnings appeared likely to remain at the same level indefinitely.

INVESTMENTS: By the time I reviewed his finances, the doctor had put away \$15,000—about nine-tenths of it in Government

THE AUTHOR heads Professional Management of Detroit. Except for some disguising of identifying details, the story he tells here is true in every respect.

WILL YOUR ESTATE PLAN WORK OUT?

bonds, the rest in mutual funds. He expected to continue investing in that proportion (an unwise plan, I thought, in view of our continuing inflation).

In addition to securities, he had a \$10,000 share in a piece of rental property. And his \$25,000 home was free and clear.

INSURANCE: "Frankly, I'm skeptical about insurance. I'd rather concentrate on building up my investments," Dr. Barnes told me. True to his lights, he had a total life insurance coverage of only \$22,500. "That's all I need," he insisted.

Inadequate Protection

I didn't agree. For a man with three children and a fourth on the way, he seemed perilously underinsured. And even the money he spent for insurance wasn't spent wisely.

He did have a \$20,000 ordinary life policy—a solid start for any program. But he'd also bought a \$2,500 retirement-income-at-65 contract. The premium on this could have been far better used to pay for an extra \$5,000 of ordinary life or \$10,000 of term insurance.

What's more, he had virtually

no disability coverage. His only protection here was provided by a disability rider on his life policy. The rider had three serious limitations: (1) It would pay only \$200 a month in case of disability; (2) it would take effect only after a full six months of illness; and (3) it was limited to specific cause.

"This is almost useless," I told the doctor. "Chances are you'd never collect a penny if you got sick." (My warning was a prophecy: He never got a cent under the rider during five months of severe illness.)

To sum it up, Dr. Barnes' financial planning was dangerously out of balance. But he had fixed views on certain things. So although I was able to point out the gaps, I couldn't prevail on him to close them all.

However, he did take the following steps:

Stocks Pay Better

1. He changed his investment program to funnel substantially more money into mutual funds and individual stocks rather than into bonds. The wisdom of this move became apparent later: The stocks appreciated about 50 per cent within three years.

2. He agreed to increase his life insurance coverage. As an absolute minimum, I advised an additional \$5,000 of cheap group term coverage, plus \$5,000 of ordinary life, plus a family income rider on his *existing* policy that would guarantee \$200 a month for twenty years after his death. He bought the term and ordinary life policies. But instead of the family income rider, he decided on an additional \$20,000 term policy.

This brought his coverage up to a total of \$52,500—about half as much as I felt he needed.

The doctor assured me he *would* bring it up to \$100,000 within the next two years. And I had to be content with this promise.

More Sickness Coverage

3. He yielded to my insistence on more—and better—disability protection by taking medical society group coverage paying \$400 a month after a month's illness. (This later provided more than \$2,000 during his last months.)

While we were talking matters over, back in 1954, the doctor told me of [More on 294]



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"Those windmills in Holland aren't worth a damn on a calm day."

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It pays to

trade words

with labor



By John R. Lavelle

Ever wonder what physicians in private practice really say when they come face to face with the labor leaders who run union health plans? This reporter pricked up his ears and listened. Here's his account of the explosive exchanges

For a moment in the moonlight I believed I was walking across a college campus designed by Cecil B. De Mille. Only the quiet voice of Dr. Robert J. Beitel Jr. telling me what he thought of union health centers reminded me that this was no Hollywood set, but Unity House, a multimillion-dollar recreation center owned and operated by the International Ladies' Garment Workers Union.

Unity House's wooded acres stand high in the Poconos, in the heart of Pennsylvania's mountain playground. Dr. Beitel and I were both there for the same reason: to attend a two-day meeting of doctors and labor union representatives. As hosts, the International Ladies' Garment Workers had brought together some fifty physicians (most of them, like Ophthalmologist Beitel, in private practice) and an equal number of union officials.

Among the guests were members of the Pennsylvania state medical society's board of trustees and representatives of the A.M.A. But a number of private practitioners without formal affiliation had also been invited. When I asked one such man why he'd come, he said cheerfully: "Because I don't like unions."

So this was obviously no ordinary meeting of union health plan partisans. That's why I was there. The conference seemed to offer a good chance to find out whether doctors can still do business with labor unions or whether relations have deteriorated beyond repair. In other words, though the topic for discussion at the meeting was listed as "The Third Party and Organized Medicine," I preferred to interpret it as "Is Peace Between Medicine and Labor Possible?"

The fact that such a meeting was called—and that it was so well attended by private physicians—indicates both sides would like the answer to be yes. "In a way, the Ladies' Garment Workers have stolen our thunder," Dr. John W. Shirer, president of Pennsylvania's state medical society, told me. "We should have called a meeting like this years ago. If we had, we might have eliminated a lot of headaches."

And when I asked Dr. Leo Price, director of I.L.G.W.U.'s health center in New York City, what the real purpose of the meeting was, his answer seemed equally significant: "I think both sides are here to learn a little

IT PAYS TO TRADE WORDS WITH LABOR



MR. WILLIAM J. HANLEY

"Labor wants more than [medicine] has been giving it," said this union adviser.



DR. W. A. BREWSTER, M.D.

"Medicine must have the right to police its own members," insisted this physician.



MR. WILLIAM MEANY

Medicine has "gone too far in emphasizing financial returns," this labor leader suggested.

about each other. Mostly, it's the Pennsylvania doctors' show. We in labor want to make an honest effort to understand their point of view. And we want them to get to know ours."

In fact, the atmospheric keynote for the whole conference was set at the first afternoon's session by a person who belongs to neither side. In a speech to the assembled group, Mrs. Agnes W. Brewster, a health insurance specialist with the U. S. Department of Health, Education, and Welfare, said:

"You doctors must be sure that yours are not horse-and-buggy or even diesel-engine ideas, because you're now deal-

ing with jet-age health insurance. And to you who represent unions, I would recommend that you have a well-prepared landing place before you attempt to soar into space."

At a predinner cocktail party on the first evening, I met, among others, George Meany, president of the A.F.L.-C.I.O. "MEDICAL ECONOMICS?" he said to me, as I was presented to him. "I didn't know doctors had any economic problems."

He smiled as he spoke. A doctor standing nearby answered him before I could. "Well, they do," he said. "And they've also got labor problems." But he too was smiling.

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GEORGE MEANY



DR. C. R. REINHARDT



DR. JOHN W. BARNES

"I didn't know doctors had any economic problems," said the A.F.L.-C.I.O.'s chief.

"Organized medicine is split wide open on economic issues," said this clinic director.

"We've come a long way toward understanding," said this medical society head.

So the over-all feeling, as I sensed it, was one of politely restrained good fellowship. The hosts were cordial but not effusive. The doctors, for their part, maintained their dignity. Many of them made no secret of their distrust of labor; but they listened respectfully to arguments they didn't necessarily agree with.

Yet below the layer of politeness a few basic issues dividing organized medicine and organized labor were quietly joined. For example, William Ross, manager of the I.L.G.W.U. Philadelphia Dress Joint Board, challenged what he called "the clichés of medical ethics, such as

free choice of physician and third-party interference." He pointed out that physicians sometimes concede that their interests are chiefly economic in any conflict between union health plans and private medicine.

"We in labor sympathize with a man's concern over the economics of his trade or profession," he continued. "But we question whether organized medicine has not gone too far in emphasizing financial returns.

"And we question, too, whether physicians have actually suffered any loss of income in areas where this union has health centers. I think that if the A.M.A. did some research in cities where

IT PAYS TO TRADE WORDS WITH LABOR

union plans are established, physicians might find that instead of a loss of income there'd been a gain."

Then the union man offered some fatherly advice: "The medical profession and the labor movement have one thing in common. In the eyes of the public we are expected to be dedicated men—dedicated to the service of our fellow human beings. Now let me tell you this: We in the labor movement suffer at the present time because the public believes we're lacking in this kind of dedication. The same thing, believe me, may happen to organized medicine."

The doctors courteously applauded Mr. Ross, as a layman and host. But—and this seemed to me the most striking aspect of the meeting—they were far less courteous with one another. A bitter debate among the medical men was sparked by the remarks of Dr. Caldwell B. Esselstyn, director of the Rip Van Winkle Clinic, an independent medical group in Hudson, N.Y.

Dr. Esselstyn pulled no punches in assailing other doctors' insistence on free choice of physician and on fee-for-service payment. Asserting that some 35 per

cent of the medical profession accepts all or part of its remuneration by other means than fee-for-service, he added: "So-called organized medicine is split wide open on economic issues."

On the one hand, he contended, there's "the old guard—rigid, dictatorial, insensitive to the changes that are going on, oblivious to the growing interest and strength of the increasingly sophisticated consumer of medical services.

"On the other hand, there's an increasing number of physicians who are eager to experiment with better ways of providing medical care, and who are eager to work out more acceptable patterns with the cooperation of the consumer.

"Unfortunately, the forward-looking element is distinctly in the minority. And minorities have no voice in the A.M.A."

When he'd finished, Dr. George S. Klump of Williamsport, one of Pennsylvania's delegates to the A.M.A., jumped to his feet. "Any doctor—and he doesn't have to be a delegate or even a member—can get up and speak his piece in the A.M.A. reference committee meetings," he said. "The A.M.A. democrat-

ically represents state and county society members. Let me tell you something:

"My county society of 150 members once objected to some action of an A.M.A. council. We picked a representative and paid his way to Denver. And we succeeded in reversing the action of that council."

Dr. Esselstyn reached for a microphone. "But, if you belong to a minority of even 49 per cent of the medical profession, you

have no representation in the A.M.A.," he replied.

A voice called from the audience in reply: "Can 49 per cent of the voters in your district elect your Congressman?"

At this point, Chairman Adolph Held of the I.L.G.W.U. interrupted. "We're not here to debate the workings of the A.M.A.," he commented. "We have enough troubles of our own."

The doctors were clearly eager



IT PAYS TO TRADE WORDS WITH LABOR

to air their differences, though. Soon afterward, Dr. Samuel B. Hadden, a Philadelphia psychiatrist, objected to what he saw as "production-line medicine" in health centers and group practice. Said he:

"Sick people need individual treatment by a physician of their choice. People can't be made well and kept well without personalized treatment. It's quite possible you can put a silver dollar in a machine and back your rear end up to the machine and get an injection. And in certain medical situations you'll get just as effective treatment as if I gave you a shot personally. Perhaps you can treat some *diseases* on a production line. But you can't treat sick *people* on a production line."

"Quite true," called out a doctor whose name I didn't catch. "But you can't blame group practice. There are individual doctors practicing on a mass basis with a string of cubicles in their offices, each for a different patient. There's the production line in solo practice."

When the time came for organized medicine to present its case formally, the job fell to Dr. W. Benson Harer of Upper Dar-

by, Pa. His major point: There should be "a formal signed contract binding on third parties and the medical profession." And such a contract must honor three all-important principles, said Dr. Harer:

1. There must be free choice of physician and hospital.

"We cannot agree with the statement of the medical director of one of the largest health and welfare funds that 'free choice has failed,'" said Dr. Harer. (He was referring to Dr. Warren F. Draper, chief medical officer of the United Mine Workers Welfare and Retirement Fund.) "We believe free choice hasn't yet had a fair trial by third parties. Furthermore, I charge flatly that labor leaders have been dishonest with some of their members by refusing to permit free choice."

In support of this statement, Dr. Harer quoted statistics from insurance companies that underwrite a number of union medical programs. These figures show, he said, that when prepaid services are restricted to certain doctors and hospitals, 35 per cent of the union members go voluntarily to the doctor or hospital of their choice and pay the

bills themselves. "Thus 35 per cent of the union members lose the fringe benefit to which they're entitled," said Dr. Harer.

2. Medicine must have the right to police its own members.

The profession doesn't demand "completely unlimited, unrestricted free choice. To do so would be unrealistic," Dr. Harer explained. He conceded that there are some doctors of doubtful competence; "and it's this group that makes health and welfare funds unwilling to grant free choice." But he warned that the responsibility of judging physicians' qualifications must be medicine's, not labor's.

3. There must be fee-for-service payment.

Granting that payment on a retainer basis might cut costs, Dr. Harer commented: "Past experience has also shown that this method of payment has almost invariably led to exploitation of doctors. Fee-for-service is preferred because it pays the physician for the work he actually performs. And it more fully guarantees that patients will receive all necessary medical care, since it removes the temptation to give

hurried or cursory attention to minor complaints."

And what does labor want from medicine?

Dr. William A. Sawyer, medical consultant for the International Association of Machinists, put it as follows: "Labor wants more comprehensive medical care on a prepaid basis. Good as they are, Blue Shield and commercial health insurance programs have not met labor's needs. Such policies in the last analysis cover only about 25 per cent of the total medical bill. So labor is not fully satisfied."

Dr. Sawyer then quoted this statement from George Meany:

"A medical care program that begins to operate only when the patient is flat on his back . . . is a program of poor quality. Yet that is the only kind that medical societies and hospital associations have, of their own volition, offered to the public."

"Of course," adds Dr. Sawyer, "labor does want to have arrangements and understandings with doctors about the accessibility of medical service, the methods of paying for it, and the use of health education and preventive efforts. Labor wants more than the medical profes-

IT PAYS TO TRADE WORDS WITH LABOR

sion has been giving it in its system of solo private practice. In other words, it is asking for an increase in the availability and quality of medical care."

In this context, an ominous note was sounded by John F. Tomayko, director of the United Steelworkers' welfare and pension department. The Steelworkers have supported the Blue plans up to now. But they may soon pull their million members out of Blue Shield, Tomayko said. The reason:

"We're under constant pressure from our members to start our own medical care program. They're paying bills out of their own pockets and they don't like it. So we've been seriously considering new means of providing prepaid health care."

This might mean, he added, that the Steelworkers would build their own hospitals like the Mine Workers, or their own diagnostic centers like the Ladies' Garment Workers.

More Unity Ahead?

When the two days of talk at Unity House were over, had medicine and labor taken any real steps forward on the road toward peaceful coexistence?

"I think we've come a long way toward understanding the other fellow's point of view," commented President Shirer of Pennsylvania's medical society. "Now I think we should follow it up by further meetings."

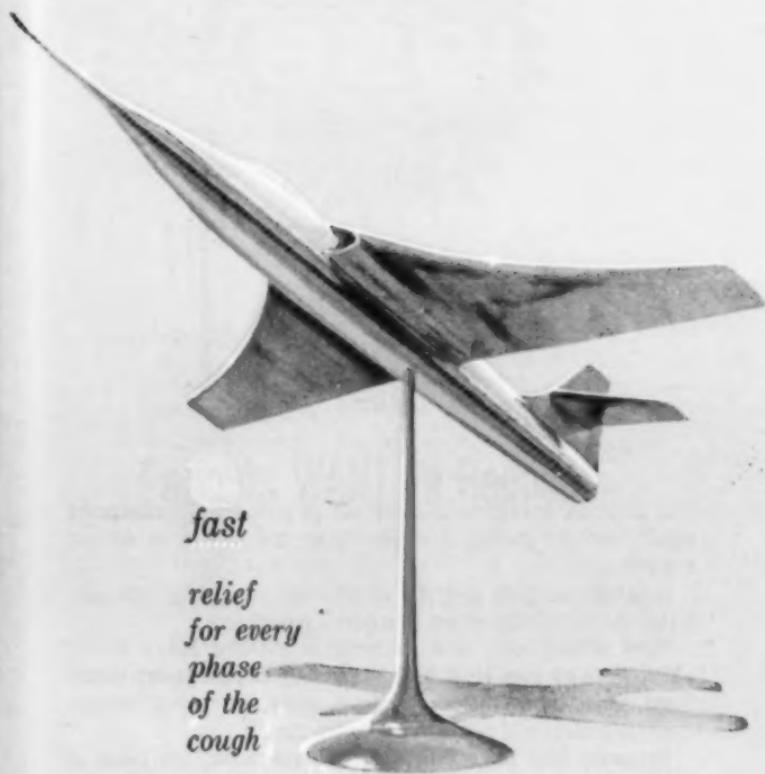
Added Dr. Edgar W. Meiser, a former chairman of the Pennsylvania society's medical economics committee: "I've always felt that if the higher echelons of both medicine and labor would learn to know each other better, they'd be taking the first constructive step toward an understanding."

"Well, has Unity House meant anything to you?" I asked him.

Dr. Meiser nodded. "I believe we've taken the first step these past two days," he replied.

Whatever the end results, medicine apparently made an impression of lasting value on at least one segment of labor. As I was leaving the meeting hall, one of the local officers of the International Ladies' Garment Workers said to me:

"You know what struck me? The way doctors feel free to criticize organized medicine. Not every union would let its members sound off against it at a meeting like this." END



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Words That Make Patients **WANT** to Reduce

If they need special treatment for obesity, they probably need special handling as human beings. Here's how experienced doctors at one weight-control clinic win their patients' cooperation

By John E. Eichenlaub, M.D.

Whenever the chair in my consulting room groans beneath the weight of a heavy patient, I groan inwardly. Considering the facts on obesity, I've got to advise him to reduce. But considering human nature, I'm unlikely to get anywhere.

The problem is almost always

the same: The patient may sincerely believe he wants to lose weight; but he's almost certain to resist the treatment he's ready to pay for. So he needs special handling as a human being if he's to get any real help from his doctor.

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MAKE 'EM WANT TO REDUCE

demolish the mental roadblocks he's likely to put in your way? In my search for an answer to that question, I recently consulted a number of doctors at our local weight-control clinic. What they told me indicates that hidden resistance by patients generally fits into a few easy-to-recognize patterns.

Why easy to recognize? Because the patient's own words often give a clue to what's wrong. For instance:

He may feel so guilty about previous failures to lose weight that he's lost faith in himself.

One clinic man told me of the following incident:

Mrs. Hendricks weighed in at 215. She stared at the floor as she mumbled, "I keep trying to lose, but I guess I haven't any will power." The physician knew right off that no medical advice could reach her until he'd helped her past her discouragement.

"But overweight doesn't come from simple lack of will power," he explained. "I suspect that, like many people today, you're under a good deal of emotional strain. Tension often causes people to eat too much, you know."

The patient looked surprised. "I thought people *lost* weight under strain," she said. *More*►



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MAKE 'EM WANT TO REDUCE

"Eighty per cent gain, and only 20 per cent lose," the doctor replied. "That's one reason why overweight is so common in our tense society. It's something many of us have to fight. And there are plenty of people like you who have to fight it harder than others."

During the long course of treatment that followed, he never let Mrs. Hendricks forget that she had no cause for shame. As a result, she became increasingly cooperative.

The patient may have decided to try to reduce only because of the prodding of others, not because he himself wants to.

A businessman looked sheepish as he told one clinic doctor his story. "I've promised my wife I'd take off thirty pounds," he said. "She thinks I'm too fat."

The doctor smiled. "I'm afraid we've found we can't help a person much if he's reducing merely to please somebody else—even his wife. The question is: Do you want to reduce?"

The patient countered with another question: "What's the average weight for my height?"

"Average weights can be misleading," said the doctor. "Take a look at the figures on this chart. These aren't exactly average

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S. Friedlander, H. S.: *The role of altrazics in cardiology.* Am. J. Card. 1:295, March 1958.

S. Shapiro, S.: *Observations on the use of meprobamate in cardiovascular disorders.* Angiology 8:504, Dec. 1957.

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weights. They're the weights at which insurance companies find their policyholders live the longest. Your chances for a longer life would be improved if you shed about thirty pounds."

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The patient knows what his ideal weight should be, but he considers it just a visionary goal that he can't possibly reach. "So what's the use of trying?" he wonders.

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titude right away," said one man. "The patient himself is likely to mention his 'ideal' weight. Then he shrugs and smiles wryly. So I tactfully steer him away from any thought of the 'ideal.' I say something like this:

"With your height and frame, it's true that the chart puts your best weight at between 134 and 143. But let's forget the chart—for now, anyway. Instead, let's set a goal that makes sense to you. I'll work with you to get to the weight you select. What figure should I write down?"

The patient usually names a figure that does seem within his reach. Thus he pledges his willingness to take a first step in the right direction.

The patient simply isn't prepared for the lonely battle that dieting can be.

I myself have found that my overweight patients have a truly wistful need for continuing support and encouragement. That's why I often tell them: "If you find yourself under any big emotional strain, weigh yourself every day. If you start to gain, telephone me right away. I'll be ready to help you, so you won't have to do it all by yourself."

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1. Granberry, C., and Beatrous, W.P.: E.E.N.T. Mo. 36:294 (May) 1957.
2. Rittenhouse, E.A.: E.E.N.T. Mo. 36:406 (July) 1957.
3. Fox, S.L.: Clin. Med. 4:699 (June) 1957.

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MAKE 'EM WANT TO REDUCE

assurance of continuing support from the doctor is an absolute must for many obese persons. As one patient has put it: "Just knowing I have an appointment to see the doctor again makes it easier to stick to the program."

To sum up what my colleagues have told me about how they handle their overweight patients: Before talking to the patient about what he should eat, the doctors try to discover what's eating him.

If he's guilt-ridden, they find ways to lighten the load. If he seems likely to resist treatment because he isn't convinced he needs it, or because he's afraid he can't stick it out, they help him understand why he can and should lose weight. Instead of demanding the impossible of him, they set preliminary goals that are actually within his reach. Above all, they give him their full personal support for the pound-shedding struggle that lies ahead.

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References

1. Arner, O., and Others: Nord. med. 58:1346 (Sept. 12) 1957.
2. Wilner, S.: Canad. M. A. J. 77:199 (Aug. 1) 1957.
3. Bruner, J. M. R.: U. S. Armed Forces M. J. 6:489 (April) 1955.
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5. Wendt, G. R., and Cameron, J. S.: Personal communication, Jan. 4, 1955.
6. Stough, A. R.: Personal communication, Aug. 10, 1957.



Is Your Practice Running You Ragged?

You've built up a successful practice. It's growing fast—almost too fast, maybe. You've got a happy home life, and you stand high in the community.

Yet you're dissatisfied. Your practice doesn't present the challenge you wish it would. The faster you run, the more you seem to be staying in the same place. In other words, you're working like a ditch digger—and what you're digging is a rut.

So what do you do?

If you're like some doctors, you look for a more limited field of practice. On the hope that it'll

be more rewarding, you tear down everything you've built up so far. You leave your trusting patients in the lurch. You quit the place that wants and needs your services. And you go back to school.

Well, I think you're wrong if you do anything of the sort without first making a big effort to improve the practice you've *got*. I was faced with this very problem some years ago. To show how it can be solved—how you can pull yourself out of a rut without flying away—let me tell you what I did:

This doctor's was—to the point where he seriously considered giving it up and going into residency. Instead, he took stock of the practice and gave it a radical overhauling. Here's what he did and how it paid off

By G. Richard Sanderson, M.D.

After five years as a solo G.P., I realized that my practice was running me ragged and that I'd have to do something about it. But I knew there was a great need for general physicians in the community. So I turned down two fine specialty residencies. I decided, instead, to try to become a better, less harassed, more useful general practitioner for my patients.

How was I to make the change? By a radical revision of my office facilities, by planned

post-graduate education, and by an increase in office personnel to take some of the load from my shoulders. In other words, by a complete reorganization of my practice.

The most important of my goals was the easiest to reach: I stepped up my program of post-graduate work in the various phases of general practice that particularly interested me. I took courses in cardiology, in electrocardiography, and in minor gynecology. And I took time out for

THIS ARTICLE has won one of the 1958 MEDICAL ECONOMICS Awards for its author, an East Coast G.P. who writes here under a pen name.



Announcing a long-acting
anti-obesity drug form whose
release rate is totally independent
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(METHAMPHETAMINE HYDROCHLORIDE IN LONG-RELEASE DOSE FORM, ABBOTT)

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NEW Gradumet DESOXYN is an anti-obesity drug in a unique automatic dosage form, because the smooth, constant release of the Gradumet depends **ONLY ON EXPOSURE TO THE LIQUIDS OF THE DIGESTIVE TRACT.** It does not depend on the acidity or alkalinity of those fluids, nor on G. I. motility, enzyme activity, chemical reactions that can vary from patient to patient —nor on any other variable.

DESOXYN, long a drug of choice in management of obesity, depresses the appetite while brightening the mood of the dieting patient. And with the new Gradumet dosage form, there is continuous all-day effect from a single dose—the entire medication is released at a uniform rate, with no 'drop-offs' in drug action.

DOSAGE is usually one Gradumet DESOXYN, 10 or 15 mg., one-half to one hour before breakfast.

SUPPLIED in three strengths—Gradumet DESOXYN Hydrochloride 5, 10 or 15 mg.—all in bottles of 50 and 500. **Abbott**

THE GRADUMET is a tiny pellet with thousands of inner passages filled with active drug. On contact with G.I. fluids, the drug begins to flow out of the passages at a steady, constant rate. The 'empty' pellet, completely inert and non-toxic, is excreted unchanged when all the drug has been released.



PRACTICE RUNNING YOU RAGGED?

more education in simple fractures and in medicine.

All of this cost me money and effort. But I felt I was investing in *me*—the best sort of investment for a physician. (And now, some twelve years later, I'm still carrying on this investment program, thoroughly sold on its value.)

My next big step was more daring. I had an \$80,000 combination home-office building; but I decided that, no matter what the extra cost, I must separate my living quarters from my working quarters. I'm convinced

it's almost impossible to lead a normal life when you live with your practice. Just moving away from it cuts your nuisance calls by more than 50 per cent.

Fewer Night Calls

I moved my family to another house and retained the older building as my professional workshop. Almost immediately, my quota of trivial night calls went way down.

Now, too, I had plenty of space for expanding my office facilities. Space properly utilized produces mobility; mobility

LOVE at first bite! with NIÑOTABS*

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Clinical reports^{1,2,3} suggest that large doses of vitamin C are beneficial in decreasing the incidence of post-traumatic and postoperative shock, in improving wound healing and in hastening the healing of extensive burns.

Vitamin B₁₂ has been suggested as an adjunct to therapy in the elderly patient undergoing operation or any other severe stress⁴ and for use in the prevention of depressed hemopoiesis and disturbed enzyme activity which may occur during severe illness, following burns, after radiation therapy, or in certain pathologic states.

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MEDICAL ECONOMICS • NOVEMBER 10, 1958 125

PRACTICE RUNNING YOU RAGGED?

properly organized produces efficiency; and efficiency produces better medical practice. Better medical practice was what I needed in order to dig out of my rut. So now I began to make some big changes.

I remodeled the secretary's station and the waiting room, partitioned off the large examining room, and improved the X-ray department and dark-room. On the second floor—our former home—I partitioned the living room into B.M.R. and ECG rooms. I turned a bedroom into an extra office where my secretary could work undisturbed on her business tasks. And I opened up plenty of storage space. (I find that supplies bought in big quantities save me over \$500 a year.)

A Lab Helps, Too

One other major change: A side porch, which had previously served as the downstairs entrance to our living quarters, was transformed into a laboratory. I equipped it with the best of everything, including a new microscope and a new colorimeter. So now I was ready to hire a lab technician.

I found an excellently quali-

fied man for the job. Since then, all my lab work has been done right in the office. It's a convenience for my patients—and a professional delight for me.

Finally, I made a *really* shocking change: I switched from afternoon and evening office hours to an appointment system that gave me my evenings free. Some of my colleagues warned me that I was committing professional suicide. Afternoon appointments only, and no night hours? Patients would never stand for it!

I myself anticipated a drop of 20 per cent or more in my patient load. But I couldn't have been more wrong.

Word soon got around that I'd drastically revised my practice so as to give me more time with my patients. People in general seemed pleased that they no longer had to wait hours to see me, and that my office was quieter and more comfortable. As for me—well, extra space and added equipment and personnel now allowed me to stay in my office for most of the work I'd usually done at hospitals. I was no longer pooped and edgy. And patients obviously liked the new me.

My practice boomed. My pa-

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THE STRIDE RITE STRAIGHT LAST SHOE...

for use in cases where normal lasts are not sufficient . . . sturdily constructed to provide a sound base for any further measures you may wish to add.



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featuring long inside right and left counters, shaped anatomic heels with $\frac{1}{8}$ " wedges on inner borders and heavy steel shanks where needed. Here again, further measures may be added.



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PRACTICE RUNNING YOU RAGGED?

tient load increased. Best of all, I was practicing much better medicine in a more relaxed atmosphere.

The amount of routine work taken off my shoulders by my secretary, my nurse, and my technician (all full-time) was unbelievable. I gave them responsibilities within their scope; and I trained them in others. So I no longer had to rush in and take an X-ray and develop it, or run a basal or an ECG. What's more,

my newly hired technician made it possible for me to set a policy of routine urinalysis and blood count on every new patient that came in.

Each of my aides freed me from one kind of burdensome routine that had been devouring too much of my time. My nurse did the dressings under my supervision. She prepared patients, weighed and measured infants, etc. And my topnotch secretary relieved me of practically all the



"I can't look it up in the medical dictionary. I don't know how to spell it!"

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"THE MOST EFFECTIVE
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brand of meclizine hydrochloride

*to prevent vertigo, nausea, vomiting
as in pregnancy*

BONAMINE gives more complete and longer-acting protection—often for 24 hours, with a rare incidence of untoward effects.² In contrast to other agents, "percentage of patients obtaining an excellent response . . . is greater . . . Also, there are fewer therapeutic failures"—"at least 90 per cent of the patients improve under this medication"²

Also indicated for vertigo, nausea, vomiting in: cerebral arteriosclerosis • other geriatric conditions • pediatric infections • postoperative patients • opiate or other drug therapy • radiation therapy, Menière's syndrome, fenestration procedures, labyrinthitis • motion sickness.

BONAMINE Tablets, scored, tasteless, 25 mg. Boxes of 8, bottles of 100 and 500.

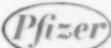
BONAMINE Chewing Tablets, pleasantly mint flavored, 25 mg. Packages of 8.

1. McKenna, C. J.: Am. Pract. & Digest Treat. 6:417, 1955. 2. Moyer, J. H.: M. Clin. North America, March, 1957, p. 405.

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PRACTICE RUNNING YOU RAGGED?

paper work that had been getting me down.

It took less than a year for my practice to mushroom—and for my interest in what I was doing to soar. That's about a quarter of the time it would have required me to get through a residency. And I accomplished the good change with no loss of income.

Only one aspect of my practice still troubled me: Since I was still doing up to 100 deliveries a year, obstetrics was cutting into my nights and making me too tired to practice the best possible medicine every day. Yet I hesitated to do anything about this problem. After all, obstetrics was bringing me in about \$12,000 annually.

Still, something had to give. I enjoyed obstetrics and the care of the entire family unit. But until I could find the right doctor-associate, it seemed advisable to give up this phase of practice. So I made arrangements with four near-by colleagues—two G.P.s and two OB men—to care for and deliver my obstetrical patients.

I now give the patients their choice. I check the newborn, see the mother in the hospital,

and do the six-week check-up. The mother and infant remain my patients, in other words, if the family wants it that way. But I don't do deliveries. So the patient who chooses to may change over to the doctor who delivers her. In such an event, I gladly arrange to transfer my records to him. (Actually, this seldom happens.)

They Wanted A.M. Visits

Once I was getting more regular sleep, I decided I felt so rested that I could now schedule morning hours two days a week. Patients had been asking for morning appointments; and I assumed that the new arrangement would help thin out the afternoon crowd. I began seeing people on Tuesdays and Fridays from 9 to 12 as well as from 1 to 6. Thus I was working in the office some nine hours two days a week.

I found the extra morning hours no hardship at all. And in one year they more than compensated me for my loss of obstetrical fees, since the anticipated thinning-out of the afternoon patient load simply didn't occur.

Significantly, I discovered



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provides the increased
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and fluid needed during
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to prevent deficiency and
help maintain resistance*

*Tisdall and Jolliffe note the systemic relation in animals between vitamin C and resistance to infection, with increased needs evident in upper respiratory streptococcal infections.

— In: Clinical Nutrition ed. by
Norman Jolliffe et al. New York,
Paul B. Hoeber, Inc., 1950,
pp. 590-91, 637-38.

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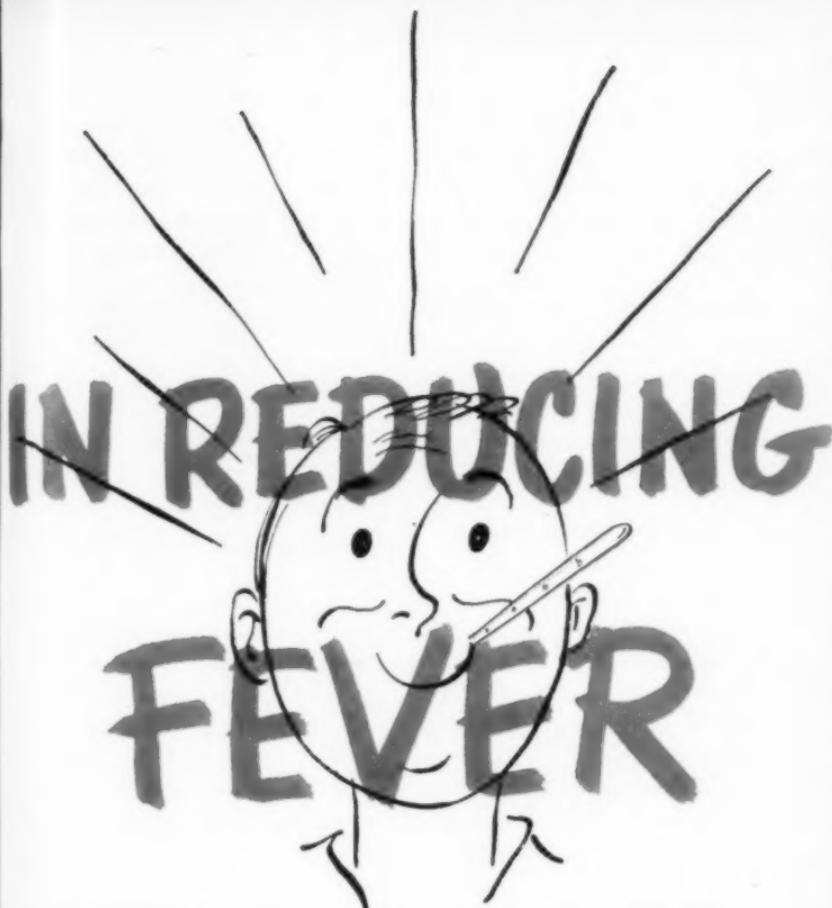
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Reference: (1) Brownlee, George: A Comparison of the Anti-pyretic Activity and Toxicity of Phenacetin and Aspirin, Quarterly J. of Pharmacy and Pharmacology 10:609-620, 1937.



In alleviating the symptoms of the common cold...fever, headache, malaise, muscular pains...why not weigh the advantages of Anacin over aspirin? Anacin Tablets exert a *better total effect* in analgesia than aspirin or buffered aspirin, in that they also relieve tension and depression—leave the patient more relaxed. Moreover, clinical investigation has substantiated that one of the ingredients in Anacin (acetophenetidin) is superior to aspirin in reducing fever...aspirin having only 60% of the antipyretic action of acetophenetidin.¹ Well tolerated. Frequent doses of Anacin may be administered without gastric upset.

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PRACTICE RUNNING YOU RAGGED?

that a growing part of my practice consisted of patients requiring psychosomatic care. These days, such patients do comprise a good portion of the G.P.'s practice. But to give them the care they need, he himself must be relaxed. The busy, hurried, and tense physician may soon lose these patients. Many of them have told me that their previous doctors were more nervous than they!

How He Stands Today

It was twelve years ago that I took stock of my practice and began to give it the overhauling it needed. Today I'm not quite 50 years old. I feel more physically fit and more mentally alert and relaxed than I did after my fifth year of practice. No ulcers, no coronary, no hypertension—I'm just downright healthy.

I have a normal life at home, and I eat my meals on time. I get plenty of relaxation. Whenever I want, I go to various medical centers for post-graduate courses, or take vacations, or do some writing. But my greatest reward is the knowledge that I've been practicing better medicine as a *satisfied* general practitioner.

General practice is "drudgery"? Not to thousands of men like myself who have determined not to succumb to the disease of "rutitis."

Whatever your field of practice, it *can* run you ragged if you let it. But if you take inventory once in a while, and if you re-organize when you feel you should, you'll prolong your life and happiness. What's more, you'll be a better doctor in every way.

END

O ne Man's Meat

Said a surgeon who got in a rut
Where his only recourse was to cut,
"I think it's a pity
The tissue committee
Gets so galled by a sound piece of gut."

—COLBY CLEVELAND

does the specific job superbly well



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ASSURE UNEXCELED ANTIHISTAMINIC PROTECTION

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POLARAMINE REPETABS, 6 mg., bottles of 100 and 1000.

Tablets, 2 mg., bottles of 100 and 1000.

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What I Learned From a Tax Audit

It wasn't much of an ordeal, says this dazed doctor: It merely took 120 hours of his time and \$2,000 of his cash! But it jolted him out of some bad habits

By Bob Miller, D.O.

My office phone rang early on the morning of April 1. "This is Harry Johnson, Internal Revenue Service," the voice said. "Your tax returns for 1955, 1956, and 1957 have been selected for audit. When would you like me to drop in to see you?"

I enjoy jokes. So I answered brightly, "April Fools' Day to you too. Coming down with a cold, Charlie? Your voice sounds hoarse."

The telephone wires frosted over. "The name is Harry Johnson," the voice said evenly. "Of the Internal Revenue Service."

In a few well-chosen sentences, the stranger convinced me of his identity. A week later,

he turned up in person—the real thing, not an April Fools' Day joke. Soon he was seated at the best desk in the office, a pile of my ledgers in front of him. He looked as if he owned the place—and I had a sneaking suspicion he would own it before he was through.

To understand why I was a bit uncomfortable about my uninvited guest, you have to know something about my business methods. Until early this year, they'd been—well, unorthodox.

For years, I've tried to combine a busy practice with running a home and a small farm. My office is in a separate building located in one corner of my



twenty-five acres of land. On the property I also have some farm buildings and my residence. And to keep my records for the whole shebang, I've relied pretty much on myself and a poorly trained office aide. (Why poorly trained? Because I trained her myself, I guess.)

I did employ an accountant to fill out my tax returns. But he never checked over the books. He simply used the information I gave him.

In the office, our methods were informal, to say the least. On busy days, my aide often hadn't time to bother with patient record cards. Sometimes she'd remember to record payments,

but she'd forget the date; sometimes she didn't get around to marking down the payment at all. If someone paid me while she wasn't around, I'd record it myself. Quite frequently, she'd later record the same payment a second time. And so on.

To set the stage even more charmingly for a tax audit, I kept only one checking account. Through it went all my business and personal checks—often one check for both types of expenditure. For example, my phone, gas, and electricity were billed separately to home and office, but I always paid them together with a single check.

And I had a few other inno-

WHAT I LEARNED FROM A TAX AUDIT

cent habits that were bound to intrigue a T-man. For one thing, since I have a talent for running out of money at the end of the year, I used to write a few thousand dollars' worth of checks and then not send them out right away. I'd drop them in the mail one by one as I collected enough money to cover them. So the date on a given check didn't necessarily indicate the day—or the year—when payment was actually made.

Then, too, there's my penchant for deficit financing. In my humble way, I've always

followed the example of the U.S. Government. My home, my farm, my car, and my professional equipment were all bought with loans. So I've written checks for much more than I've earned in recent years.

Cause for Concern

Of course, I knew I wasn't guilty of larceny or fraud. But when Harry Johnson of the I.R.S. moved in on me, I couldn't help sweating. What would *he* think of my raffish financial ways? (He didn't think much of 'em, let me tell you.) *More*►

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Reference: Baird, H. W., III.
A comparison of Meprospan (sustained action meprobamate capsule) with other tranquilizing and relaxing agents in children. Submitted for publication, 1958.

CME-7331 *TRADE-MARK

Just to give you an idea of what a tax audit can be like for any doctor who keeps fuzzy financial records, here's a blow-by-blow account of what happened:

The First Blow

At our first encounter, my visitor grabbed a bundle of patient record cards from my files. He motioned me hospitably to a chair at his side. Then, as he called out the name and date of each treatment, I had to show where the amount charged was listed in the day book. I'd figured

my gross income from the totals in the day book; so I suppose this cross-check was to see whether I'd been reporting all my income for the period.

In view of the bad habits of my aide and myself, I was scared to death. Sure enough, the fifth item he called out had never been marked down in the day book. For a total of twenty hours—not all in one day, luckily—we carried on the cross-checking routine. And it became grimly apparent to both of us that plenty of payments hadn't been recorded.

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Each LP tablet contains:
Phenylephrine hydrochloride, 20 mg.
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Usual dose: Two tablets, morning and evening. For mild cases (and children), 1 tablet. Occasional patients may require a third daily dose, which can be safely given.

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TAX AUDIT

Fortunately for me, the total of *twice-recorded* income just about equaled the total of *uncrecorded* income.

"Well, that cancels out," I said hopefully, when we'd finished this phase of our mutual operation. The T-man answered not a word.

His next step was to run through every check I'd written for the last three years. It was my job—in general, I worked along as his unpaid assistant—to sort the checks into two piles, business and personal. But what could I do with the checks that were part business and part personal? Tear them in half? I didn't know, and I had to tell him so.

It was embarrassing.

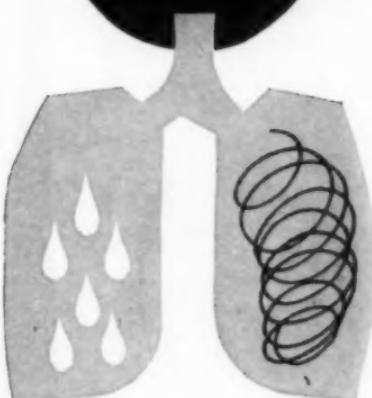
He Checked at the Bank

After he'd run out of checks to shuffle, he next paid a visit to my bank. I suppose he had to. It used to be another of my bad habits to discard monthly bank statements once I'd verified the figures.

At the bank, he discovered that my outgo exceeded my income by a considerable margin. I explained my adventures in deficit finance. He seemed to understand. But he kept making notes and not committing himself. The suspense was awful.

Throughout the long audit, in

when the patient
needs relief
from tenacious
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Each 5 cc. teaspoonful contains:
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Dihydrocodeineone bitartrate 1.66 mg.
Ammonium chloride 135.0 mg.
Sodium citrate 84.5 mg.
Chloroform (approx.) 13.5 mg.
I-Menthol 1.0 mg.
(Alcohol 5%)

Dosage: Adults—2 teaspoonfuls, three or four times daily. Children— $\frac{1}{2}$ the adult dose. Infants— $\frac{1}{4}$ to $\frac{1}{2}$ teaspoonful, three or four times a day.

Supplied in pint and gallon bottles.



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Prophenoxydramine maleate.....	12.5 mg.
Dihydrocodeinone bitartrate.....	1.66 mg.
Chloroform (approx.).....	13.5 mg.
I-Menthol.....	1.0 mg.

Supplied in pint and gallon bottles.

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TAX AUDIT

fact, he said practically nothing. At times I thought I knew what he was doing; other times, I wasn't so sure. Usually I thought he knew, but sometimes I wasn't even sure of that.

As each new fragment of information was dredged to the surface, I kept wondering how it fitted into the jigsaw puzzle of facts and figures. And when a pattern finally began to emerge, I was afraid it looked uncomfortably like bars and stripes.

By the time the T-man had been with me for a month and a half, I'd begun to think he'd hang around until he retired. Actually, though, he didn't spend all his waking hours with me. He seemed to be working on several different returns at once. He would dash in and out at odd times. Sometimes he'd break appointments. Often he'd take my books away with him to work on at home.

Judgment Day

But at last he was finished. On the day of reckoning, he and I sat down across a table to review my sins of omission and commission.

"Dr. Miller," he began sadly, "I suppose some doctors have worse business records. But I've never seen any." *More* ▶

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—Richard T. Smith
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"Protamide is a valuable remedy in the treatment of herpes zoster. It is helpful in relief of pain and apparently aids in involution of the cutaneous lesions."

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NEW YORK STATE JOURNAL
OF MEDICINE

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—Prof. F. Caramazza
ITALIAN JOURNAL OF
OPHTHALMOLOGY

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—William C. Marsh
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TAX AUDIT

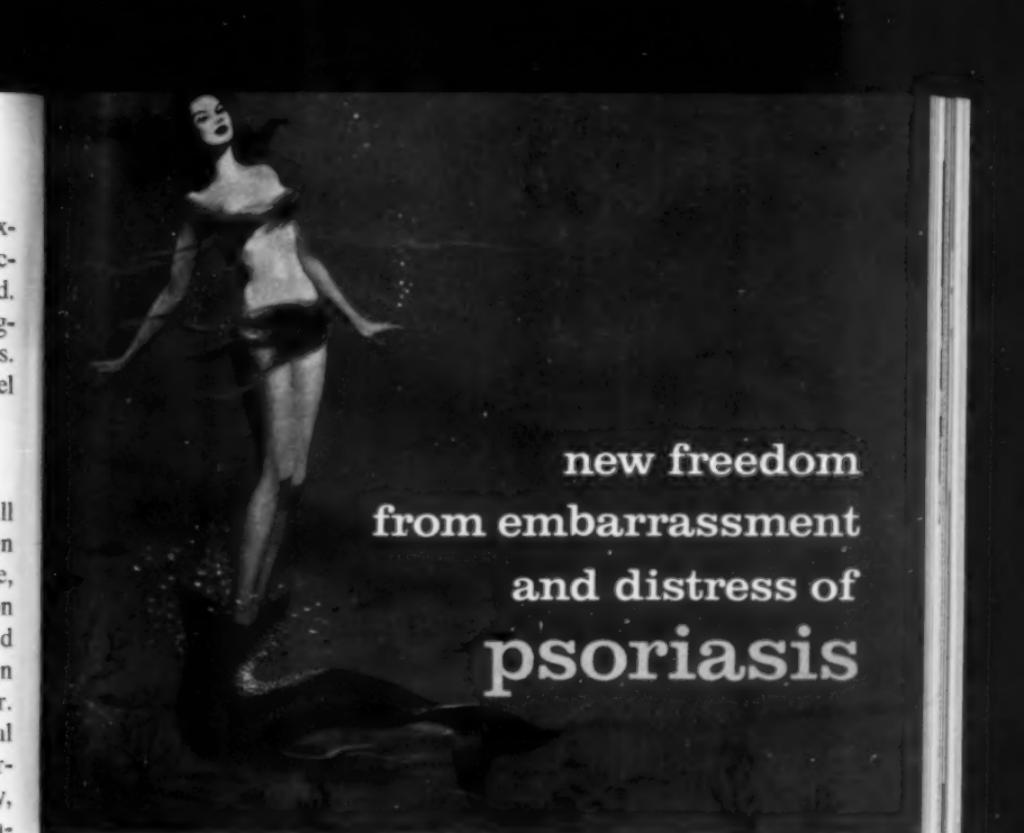
On gross income, he explained, he was prepared to accept the figures I'd reported. There were errors. But he recognized them as honest mistakes. And, as I've said, they did cancel out.

Deductions Canceled

But he was disturbed by all sorts of items I hadn't even worried about. For instance, there was the casualty deduction I'd claimed for a beautiful stand of hardwood trees destroyed in a tornado. "Oh, no," said Mr. Johnson (which wasn't his real name, by the way). "That tornado *improved* your property, Doctor. It gave you more sunlight." Ergo, no deduction.

Then there were my deductions for depreciation on professional equipment and office improvements. During the past few years I'd bought a lot of expensive stuff; and I had remodeled my office to twice its former size. I'd charged off those expenses over a five- to seven-year period. And I certainly didn't expect to be challenged on this score.

But he came down hard on me. I'd taken the deductions too fast, it seemed. The T-man made his point with the help of a tax booklet he carried with him. According to the slim volume,



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(1) Flesch, P.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (2) Bleiberg, J., and Saltzman, J. A.: Clin. Med. 5:485 (Apr.) 1958. (3) Bleiberg, J.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (4) Clyman, S. G.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press). (5) Samitz, M. H.: Reported Conf. N. Y. Academy Sciences May 9, 1958 (In Press).



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WHAT I LEARNED FROM A TAX AUDIT

equipment should last twice as long as it actually does. So the depreciation period for my stuff was stretched out. I had to pay up.

He Wasn't Penalized

My additional tax bill for the three-year period in question came to almost \$2,000, plus 6 per cent interest. But my T-man apparently realized I'd made an honest effort to pay my fair share of taxes. He said absolutely nothing about negligence or fraud penalties.

So I don't feel the Government roughed me up too badly. I paid the final bill with a sigh of relief, grateful that those years were in moth balls and that I could now go back to making a dollar to pay taxes on (and with).

But I'd rather not sweat through any further marathon audits. That's why I've changed my bookkeeping methods. I now have two aides instead of one; and I'm trying to train them right.

I delegate the work sheet, the patient cards, and the day book to *both* girls. Each checks the daily figures independently, and I match their answers against the cash received. Only if all three

totals agree do we accept the figures.

I've also set up separate checking accounts for business and personal affairs. And I've increased the responsibility of my accountant. He now checks each day's work sheet, all receipts, every deposit slip, and all professional expenditures.

There's nothing remarkable about my current bookkeeping routine, of course. It's standard operating procedure for a well-run office. But mine *wasn't* well run. And since my audit, I've talked to scores of other men whose methods seem as haphazard as mine used to be. For instance, take one doctor I know.

He's Asking for It

He has three checking accounts—one for his office, one for himself, one for his wife. Trouble is, he pays his professional expenses from all three—depending on which checkbook is handiest when the bill comes in.

I bet the T-men will hang around *his* place till doomsday trying to straighten out the mess. And don't think they won't turn up there sometime soon. Slovenly bank accounts attract the Rev-

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PUBLISHED REFERENCES: 1. Carpenter, E. B.: Southern Medical Journal 31:627, 1938. 2. Forrester, H. F.: J.A.M.A. 167:162, 1958. 3. Little, J. M., and Truitt, E. B., Jr.: J. Pharm. & Exper. Therap. 119:161, 1957. 4. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J. Am. Med. Assn. 167:2424, 1958. 5. Morgan, A. M., Truitt, E. B., Jr., and Little, J. M.: J.A.M.A. 167:160, 1958. 6. Park, H. W.: J.A.M.A. 173:188, 1959. 7. Truitt, E. B., Jr.: Southern Medical Journal 40:322, 1957. 8. Truitt, E. B., Jr., Patterson, H. B., Morgan, A. M., and Little, J. M.: J. Pharm. & Exper. Therap. 119:160, 1957.

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STUDY 1¹		"marked" ^{1, 2}	moderate	slight
Skeletal muscle spasm secondary to acute trauma	33	26	6	1
			—	—
STUDY 2²		"pronounced"		
Herniated disc	39	25	13	1
Ligamentous strains	8	4	4	—
Torticollis	3	3	—	—
Whiplash injury	3	2	1	—
Contusions, fractures, and muscle soreness due to accidents	5	3	2	—
			—	—
STUDY 3³		"excellent"		
Herniated disc	8	6	2	—
Acute fibromyositis	8	8	—	—
Torticollis	1	—	—	1
			—	—
STUDY 4⁴		"significant"		
Pyramidal tract and acute myalgic disorders	30	27	—	2
			—	1
TOTALS	138	104	28	4
		(75.3%)	(20.3%)	

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"This study has demonstrated that methocarbamol (Robaxin) is a superior skeletal muscle relaxant in acute orthopedic conditions."

WHAT I LEARNED FROM A TAX AUDIT

enuers like the aroma of sour mash.

Now I have just one suggestion to make to the I.R.S.:

I think they ought to teach their agents how to do the auditing job in a bit less than the two months it took Harry Johnson to finish mine. I figure that the audit consumed about sixty hours of his time and about twice as much of mine and my aide's.

Granted, much of the delay was the fault of my own bad bookkeeping. But much was also the Government's fault. Mr. Johnson was hard-working and

apparently fair-minded. He simply had too much to do—too many cases to deal with simultaneously. He always seemed to be in a rush to get somewhere else.

After our last meeting, in fact, he flew out the door so fast that he left behind some souvenirs of the audit. I still have his folding cup and muffler. When I look at them, I recall my final glimpse of him rushing off to another appointment somewhere.

Whose office, I wonder, was he in a hurry to get to? Could it have been yours? END

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1. Gould, W. L.: *Impotence*, *M. Times* 84:302 Mar. '56.

2. Personal Communications from 110 Physicians.

3. Milhoan, A. W., *Tri-State Med. Jour.*, Apr. '58.

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Are Doctors Subsidized by Society?

They never pay the full cost of their education, a columnist complains. Answer: They repay it in other ways

By R. W. Tucker

Should doctors reach into their own pockets to pay the full costs of their medical school education? Yes, says Sydney J. Harris, a columnist for the Winston-Salem (N.C.) Journal and other newspapers.

He argues that medical students pay only \$600 to \$900 a year tuition, while their training costs the school about \$4,000 a

year per student. Doctors could well afford to repay the difference, he adds, because their incomes are "the highest in all professional brackets."

What's the answer? That doctors already *do* subsidize their own training, according to Dr. Wingate M. Johnson, editor of the North Carolina Medical Journal. He points out:

ARE DOCTORS SUBSIDIZED BY SOCIETY?

"Mr. Harris overlooks the fact that young doctors, after getting their M.D. degrees, serve as hospital house officers from one to eight years, or longer, for starvation wages or for nothing . . .

'A \$12,800 Subsidy'

"Subtracting the student's average tuition fee—at least \$800 a year—from . . . the actual cost of his education leaves a 'subsidy' of \$3,200 a year, or \$12,800 in four years.

"Since the average young doctor could earn at least \$10,000 a year in practice, but serves

three years as a hospital house officer for not more than an average of \$1,800 a year, it seems fair to subtract this sum from \$10,000 (or more). This would mean that he pays back to society the equivalent of at least \$8,200 a year—or \$24,600 for three years.

"This is \$11,800 more than the 'subsidy' given him by society," Dr. Johnson's editorial in the Journal concludes. "How many other professional men, Mr. Harris, come as near repaying their debt to society for their education?"

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'Sliding-Scale Fees Are Still the Best'



Far from 'soaking the rich,' charges based on your patient's ability to pay are fairest to both you and him, this management man says

By J. Paul Revenaugh

Doctors who charge according to the patient's ability to pay are being called harsh names these days. They're "medical Robin Hoods." They "soak the rich." And so on.

The modern idea seems to be that every doctor should set a fee schedule based on his own evaluation of his services; and deviations, if any, should be downward only. In other words, the consensus seems to be that standardized fees are the only fair fees.

Well, at the risk of appearing old-fashioned, I beg to

THE AUTHOR has been a professional management counselor for a quarter of a century. He heads Professional Business Management, Inc., Chicago.



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SLIDING-SCALE FEES

disagree. In my opinion, standardized fees *aren't* fair because they put the emphasis in the wrong place.

Chickens vs. Cows

When a physician draws up a constant fee schedule, he's thinking of what each service is worth to *him*. Thus, he's neglecting the essential question of what it's worth to the *patient*. In the old days, when doctors were paid in kind, they were willing to accept a chicken from one farmer in return for a certain medical service; but they were apt to want a cow from a wealthier farmer for the same service.

What's in a Dollar?

Seems to me they had a good point. After all, the value of money is a pretty relative thing.

Think of the vastly different meanings a dollar bill has for different people. A scrubwoman may view it as the wherewithal for her next day's food. A well-to-do businessman may think it just enough for a casual tip. These varying points of view should certainly be taken into account in setting medical fees.

The real worth of a service is *its value to the recipient*. Lawyers, architects, even clergymen generally establish their fees that

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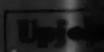


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SLIDING-SCALE FEES

way. Many businessmen who offer a personal service do, too. Why not physicians, then?

How to apply this principle to medical fees? The most practical method, in my experience, is to establish charges in terms of a patient's income. The problem doesn't arise, of course, with routine office visits and house calls; such services should be on a flat fee scale. But fees for *major* services can be quite simply graded in any way you choose.

You might, for example, decide that a life-or-death operation is worth one month of a patient's income. An appendectomy might be worth one week or ten days of his income. Other common procedures can usually be fitted into this system without difficulty.

Result: a rough but simple fee schedule that automatically reflects the value of the service to the patient, since it's geared to his income. There's nothing new



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SLIDING-SCALE FEES

about this principle, of course. Doctors have been using it for several thousand years. But *how* it's used is all-important.

In most cases, the doctors I've worked with have found it practical to give a patient a yardstick and let *him* set the fee. This makes it virtually certain that the doctor will treat him fairly—and that the patient will realize it and be satisfied.

What to Tell Them

No set wording can be prescribed for explaining this procedure to patients. But one doctor I know handles it something like this:

"Now, Mr. Scoville, we come to the hardest part of this business—at least for me. That's the problem of deciding on a fair fee. I don't mind telling you, we usually figure that this particular service is worth about one week of the patient's income. But the important thing is for you to be completely satisfied. So here's what I'm going to suggest: I want *you* to set the fee, using what I've told you as a rough yardstick."

This discreet turning of the tables gives the patient little time to demur—even were he so inclined. Nearly always, he'll name

a pretty just figure—often saying something like this: "Well, does \$150 sound about right?"

To which the doctor can reply: "If it seems fair to you, it's certainly satisfactory to me." His chances of collecting the fee are far better in such cases than if he set it independently.

What about the occasional patient who tries to take advantage of you? If the fee he names seems ridiculously low, you can say something noncommittal like, "Well, suppose we call that the tentative fee." If a routine credit investigation later shows the patient was pulling a fast one, he can be billed for the exact "one week's income"—or whatever. An accompanying explanation will almost always make collection of the correct amount possible.

It Fosters Trust

Mostly, though, the technique works without need of check-up, for it's based on mutual trust. It not only is based on it; it strengthens it. And that's good for both doctors and patients.

Fees set this way are fair to both the rich and the poor. After all, they reflect the real value of the service to the recipient. Fur-

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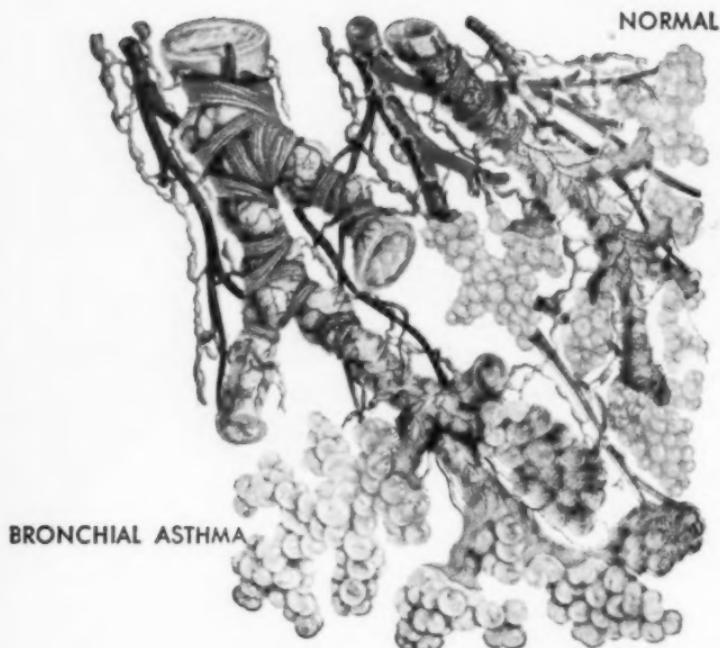


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SLIDING-SCALE FEES

thermore, patients themselves understand and welcome such consideration.

Some time ago, a doctor-client of mine performed an extremely delicate operation on one of America's wealthy businessmen. There could be no doubt that the surgeon had saved the man's life. So when the time came to talk about fees, the surgeon spoke frankly:

"I know it sounds absurd in your case," he said. "But my customary charge for life-or-death work is a month of the patient's income. As I say, that's my *customary* charge. I'd prefer to leave the fee up to you this time."

The businessman accepted the arrangement, and a few weeks later he settled the bill. What the surgeon got was a couple of thousand dollars in cash, another couple of thousand in stocks, and a still undetermined amount in stock rights. Altogether, he will have received many thousands of dollars for his services in that one case. Yet the patient set the amount and considered it fair.

Or take the case of a railroad president, on whom another surgeon performed a major stomach operation. Told that the doctor's customary charge in such cases

was one month's income, he set his own fee at \$3,500. Both parties were satisfied. It didn't matter that the man actually earned \$5,000 a month, as the doctor later learned.

Why Not Fixed Fees?

By contrast, here are some of the difficulties that fixed fees can lead to:

Another railroad man—a rank-and-file worker, not a president—underwent a stomach resection. The doctor charged him his standard fee—\$500. Weeks went by, and the bill wasn't paid.

Finally, the case came to me for investigation. I discovered that the man had a large family and that \$500 was clearly beyond his ability to pay. At my suggestion, the bill was reduced to \$200.

That man actually went out and borrowed \$200 from his friends so that he could pay the doctor in three days. He wanted to pay, but simply hadn't been able to—because the fee wasn't geared to his means.

Another fixed-fee case that came to my attention recently involved a nationally known surgeon in Chicago. Without even asking about a certain patient's

SLIDING-SCALE FEES

economic status, he'd billed the man for his standard fee of \$300. The patient had sent in \$100 and then hadn't been heard from for weeks. Finally, when the matter was followed up, the story came out:

The \$100 represented the man's whole fortune. He was old and frail. Yet he planned to go back to work in a filling station as soon as he could in order to pay off the rest of the \$300.

To the surgeon's credit, he not only wrote off the unpaid \$200 but sent back the man's original \$100. Yet his fee-setting error caused embarrassment to all. It would never have happened except for his reliance on standardized fees.

Doctors who use the sliding-scale technique *know* they're doing right by their patients. What's more, the patients know it too. Of such stuff are the most enduring doctor-patient relationships made. **END**



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**Blue
Cross-
Blue
Shield
Jurisdictional
Dispute
Divides
Doctors**

By Lois R. Chevalier

While hospital-sponsored plans and doctor-sponsored plans compete with each other, medicine in one state is split wide open by recriminations against a secretary, the resignation of a president, and violent reactions from M.D.s

"Gentlemen, I hold no rancor," said the stocky, balding man at the podium. "But I feel amazement and astonishment that you've elected to go along with a lay secretary instead of with your confreres in medicine."

"Doctor, we will have no more personal recriminations," said the speaker of the Wisconsin State Medical Society's House of Delegates, rapping sharply with his gavel.

"I am only going to tell facts," the man at the podium went on. "On Aug. 9, 1958, the secretary of this society, Mr. Charles Crownhart, said, and I quote from my notes: "I'll push the western boundaries of Milwaukee County into Lake Michigan, and if some of the doctors fall in, so much the better."

There were murmurs and calls

from the delegates around the room. The man at the podium put his hand up to his throat.

"As I remove this ribbon with the attached medallion and place it lovingly in this case . . . it is with a sad heart that I resign the presidency of the Wisconsin State Medical Society. You have recommended that the Council revoke my county society's charter. Gentlemen, I have no choice."

With these words, Dr. Jerome W. Fons turned and left the room. In the uproar that followed, most of the Milwaukee delegates got to their feet and filed out behind him. Outside in the hall they saw that Dr. Fons had tears in his eyes.

Inside, the remaining delegates slowly came back to order. Dr. L. O. Simenstad, a past

BLUE CROSS-BLUE SHIELD DISPUTE

president of the Wisconsin society, moved a vote of confidence in Secretary Crownhart and his staff. The motion carried by a voice vote.

How did things come to this pass in Wisconsin? It's a complicated story that goes back a long way; but basically it's a battle over competing health insurance plans.

Picture this, if you can:

In Wisconsin at present, there are two rival state-wide Blue Shield plans offering medical-surgical coverage. One of them is sold exclusively by Blue Cross. The other, with its own sales force, is offering a new rider to cover hospitalization too.

For the moment, there's just one state-wide Blue Cross plan to pay hospital bills. But it has organized a subsidiary corporation to sell medical-surgical coverage as well. Furthermore, there's serious talk of organizing a second Blue Cross plan.

When the curtain rose on the present conflict early this year, the stage wasn't quite so crowded. There were:

¶ *Surgical Care*, the Blue Shield Plan of Milwaukee, owned, operated, and staffed by the county medical society and

limited to operations in Milwaukee.

¶ *Wisconsin Physicians Service*, sometimes called Blue Shield of Wisconsin, owned, operated, and staffed by the Wisconsin State Medical Society and sold everywhere in the state except Milwaukee.

¶ *Associated Hospital Service*, the Blue Cross plan that contracted to serve also as selling and enrolling agent for both the doctor-sponsored plans.

Down through the years, Surgical Care of Milwaukee has got along amiably with Blue Cross. But Wisconsin Physicians Service has not. The bad feeling broke into the open last January, when Wisconsin Physicians Service and Blue Cross dissolved what Crownhart called their "marriage of convenience."

According to the state society secretary (who also heads Wisconsin Physicians Service), W.P.S. was being charged \$180,000 a year by Blue Cross for its sales work—and Blue Cross was making a profit of \$60,000 a year on it.

One expense item in particular roused Crownhart's ire. Blue Cross, he said, was "charging the salaries and fringe benefits of its

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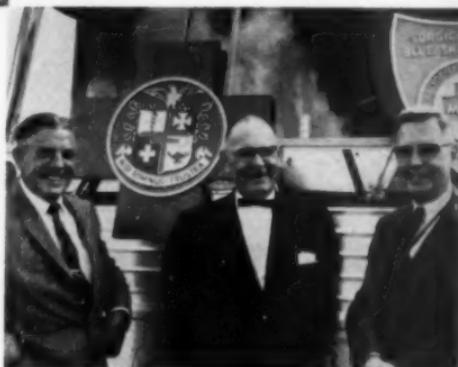
BLUE CROSS BUILDING in Milwaukee is about one-third larger than it needs to be for current operations, say those who believe Blue Cross is empire building at doctors' expense.



THE ACCUSERS. Drs. Robert Purtell, Jerome Fons, and Donald Willson, sided with Blue Cross and against Crownhart. They lost out in a dramatic medical society meeting.



CHARLES CROWNHART, lawyer, lay secretary of the Wisconsin State Medical Society, head of Wisconsin Physicians Service, has also been accused of empire building.



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two principal executives as a joint expense of Wisconsin Physicians Service, Surgical Care, and Blue Cross. The amount involved is over \$100,000 for two men alone. I think it is unethical."

Crownhart's blast at Blue Cross drew return fire from an unexpected quarter—from Milwaukee doctors. State insurance department files, they said, showed the combined salaries of the two Blue Cross executives to be \$45,000.

"Neither of these two executives receives a salary as large as is paid the secretary of the state medical society,"

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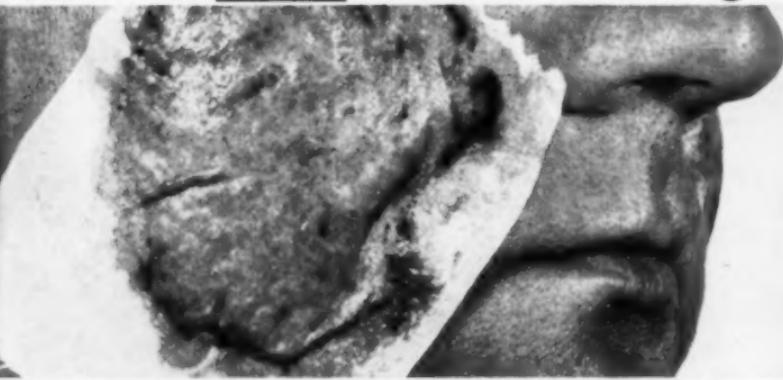
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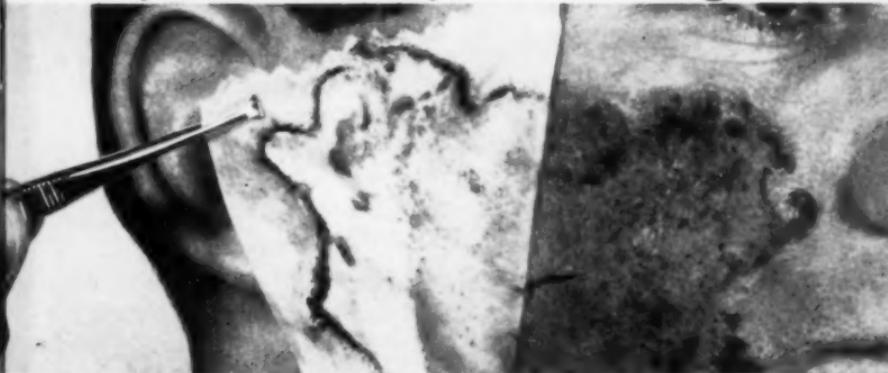
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Thomson, J. E. M.: Am. J. Surgery 91:413, 1956.

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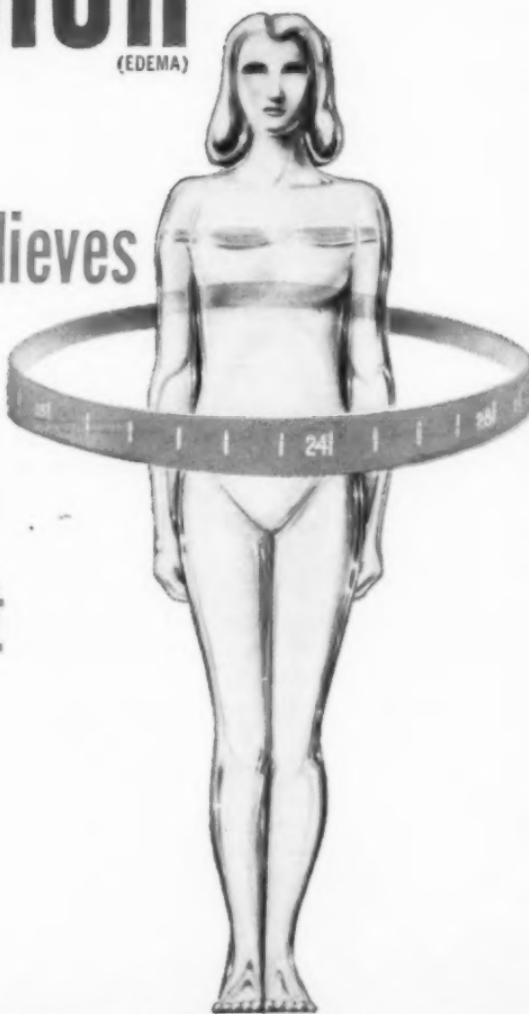
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MEDICAL ECONOMICS • NOVEMBER 10, 1958 185

BLUE CROSS-BLUE SHIELD DISPUTE

the Milwaukee M.D.s added pointedly.

They also cited figures indicating that Blue Cross sales

charges weren't out of line—and that Wisconsin Physicians Service administrative costs were. W.P.S. spent 15.6 per cent of its

Keep Your Eye on These Issues

You may find it hard to believe that *your* medical community could ever get involved in a bitter conflict like the one reported here. And yet the conflict involves some basic questions being asked in other states. Watch out for these three:

1. ARE HOSPITAL PEOPLE DOMINATING THE DOCTORS' HEALTH PLANS?

In Wisconsin, according to the state medical society, Blue Cross was charging the doctor-sponsored plan too much for selling its policies; it wasn't pushing the contracts the doctors thought ought to be pushed.

2. WHAT'S THE PROPER DIVIDING LINE BETWEEN BLUE CROSS AND BLUE SHIELD COVERAGE?

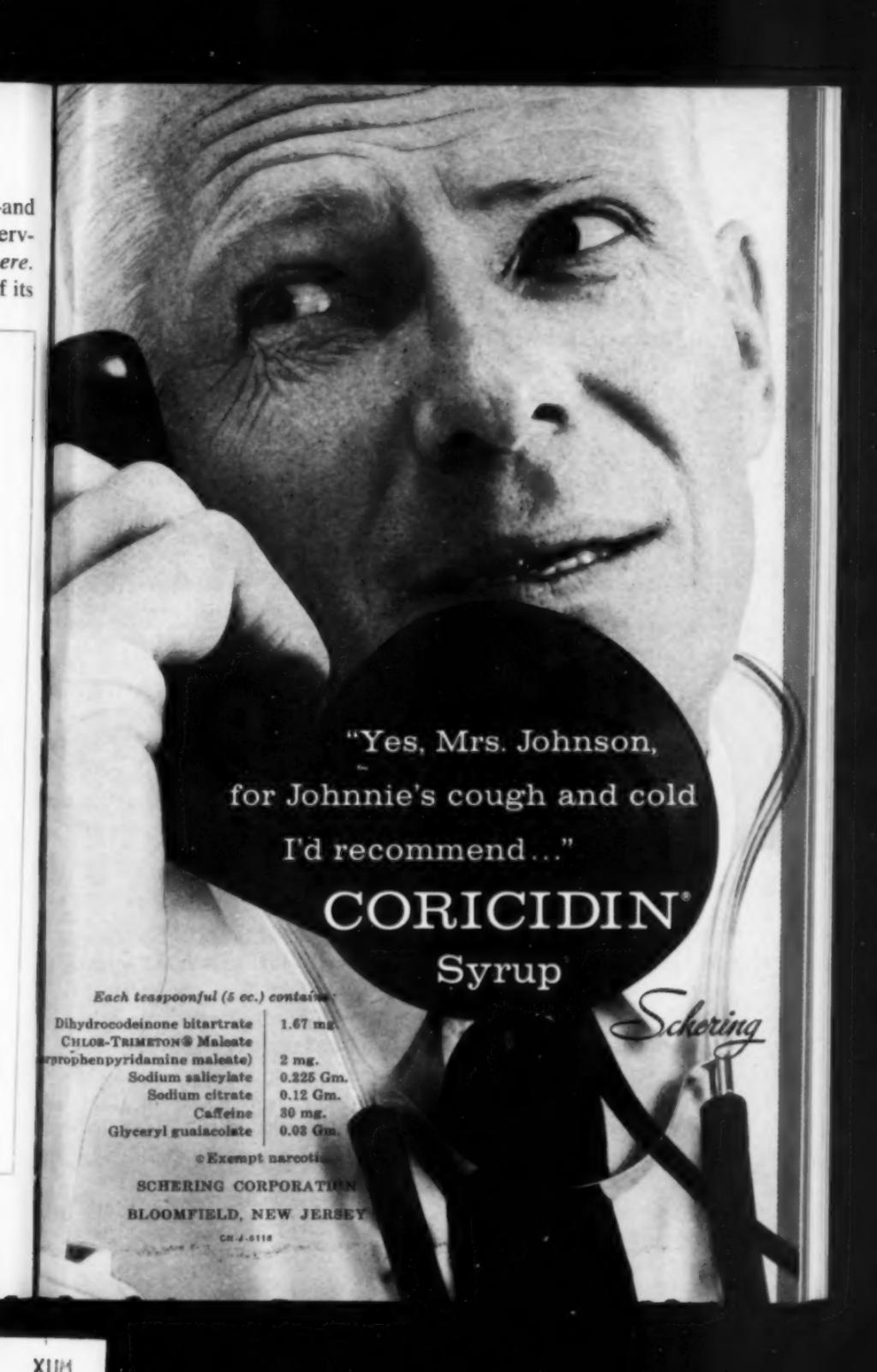
Such services as anesthesiology, pathology, and radiology are covered by Blue Cross in some places, by Blue Shield in others. Lacking a satisfactory boundary, both Blue Cross and Blue Shield in Wisconsin ended up selling a complete package (medical, surgical, and hospital coverage) in competition with each other.

3. HOW MUCH STATE REGULATION OF HEALTH PLANS IS DESIRABLE?

"There's too much already," some Blue Cross officials say. They haven't been able to get their premiums increased because of political opposition. But Wisconsin doctors have voted for *more* state supervision over the Blue plans. They think it's a necessary curb on Blue Cross.

You'll find other important issues discussed in the accompanying article. But keep your eye on the three listed above. They can cause an explosive reaction if the control rods are ever pulled out.

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income on overhead, they reported, whereas Surgical Care of Milwaukee was run for 11.3 per cent.

The reason for this return fire? Milwaukee doctors felt strongly that medical men had lost control of the state medical society. And soon they were circulating a thick document in support of their views.

"THE ISSUE IS THE WAY THE STATE MEDICAL SOCIETY IS RUN," the document said. Then it asked a series of charged questions:

The 'Inner Circle'

"How many delegates can recall serious policy decisions that have taxed this House of Delegates? How many delegates feel that the House has become merely a figurehead and rubber stamp for activities of the society carried on by an 'inner circle'?"

"No one will refute the statement that Drs. Steve Gavin and R. G. Arveson are real statesmen of medicine from Wisconsin. Have we asked too much from these men? Can anyone remember when last some other physician was chairman of the Council?"

"What is the role of the secre-

tary of the state medical society? Why is he not an executive secretary, and therefore in the proper category of an employe? What factors . . . led this society to do what no other society in the nation has done . . . elect a layman to membership . . . and as secretary? To whom does he report? Who gives him his orders? . . . Has there been administrative arrogation of power?

"Is it good policy for a society to employ the legal firm of which its secretary was formerly a partner? Does a conflict of interest exist in this relationship?

"Who makes the decisions in the state medical society? Who decided that the Blue Cross matter not be referred to the House of Delegates? Not by the greatest stretch of imagination was this an 'administrative detail.'"

Why the Questions?

The point of all these questions was this: Milwaukee M.D.s wanted a study of the state society by an outside managerial consultant. They formally requested it at the May meeting of the Wisconsin House of Delegates. But the upstate delegates, apparently not excited by the

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thinly veiled accusations, turned down the request.

Then Milwaukee doctors decided they'd have to do something drastic on the health insurance front. Wisconsin people were used to buying health insurance in a package. Because of the separation of state-wide Blue Cross and Blue Shield, they could no longer do so.

Fewer New Members

"All the Blue plans were suffering losses in enrollment," according to Dr. S. A. Morton, president of the Milwaukee

medical society. So he and his Surgical Care colleagues decided to move into the gap:

"Blue Cross had been asking us to expand our geographical area for months. Finally, on May 26, we voted to let them sell Surgical Care in the ten counties around our own."

That started a wild flurry of new health insurance offerings—all of them well outside the insurer's customary field. Within a matter of weeks:

1. Wisconsin Physicians Service was offering *hospitalization* in a rider to its contracts.



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2. Blue Cross had organized a new Health Insurance Corporation (quickly shortened to HIC) to sell *medical-surgical* coverage on a cash-indemnity, aim-for-profit basis.

More Competition

3. Surgical Care of Milwaukee decided to go *state-wide*. Since Blue Cross could sell this coverage in combination with its own, it soon deactivated HIC.

At least that clarified the jurisdictional dispute. It was Wisconsin Physicians Service vs. Surgical Care and Blue Cross. Both

sides were selling medical, surgical, and hospital insurance state-wide. Wisconsin doctors were on both sides—and caught in the middle.

That's why, on a sunny weekend in late September, the Wisconsin House of Delegates met in special session at Stevens Point. This tiny town had been chosen because it was no man's land in the current war between Milwaukee medicine and upstate doctors. Its only hotel was barely large enough to house the delegates. The Milwaukee doctors chose to live in a motel out

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BLUE CROSS-BLUE SHIELD DISPUTE

where the tree-lined streets began to give way to farms.

The two groups mixed amiably the first day. The doctors even made fun of their feud. "We're not taking it as bad as those poor fellows in Connecticut," one of them said proudly at dinner.*

But when the House reconvened for a night session, the doctors were ready to get down to brass tacks—or brass knuckles. Just two main possibilities for solving the problem had been presented:

Two Alternatives

First Solution: Let the state medical society run a parent Blue Shield plan. Any county society wanting to run a plan of its own could do so under the supervision of the state society. But since "the lay incumbents" now administering the two competing Blue Shield plans had failed repeatedly to solve their differences, let them be relieved of all "administration and management of such Blue Shield plans."

Second Solution: Make every county society amend its bylaws so that it could not conduct any

operation within the territorial jurisdiction of another county society "unless with the formal consent of that society and with the approval of the state medical society," on pain of revocation of its charter. Maintain just one Blue Shield plan in the state. But let the state society grant franchises to any county society that wanted to run "a branch of the mother plan within that county."

Milwaukee delegates supported the first proposal. The Council of the state medical society supported the second. The reference committee moved toward the middle: It picked the first solution but softened it by leaving out the part about firing lay administrators.

Status Quo?

That satisfied nobody. "The reference committee has emasculated the resolution they recommend," cried one delegate. "The sense of it now is that things should continue exactly as they are."

"We've come all the way up here to settle this thing," another doctor protested. "Let's settle it!"

"The trouble with that Mil-

*See "Blow-Up Over Blue Shield," MEDICAL ECONOMICS, Sept. 1, 1958.

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a new potency for
greater dosage flexibility
in treating the **menopause**



SUPPLIED: Bottles of 60 tablets.
DOSAGE: One tablet t.i.d. in 21-day courses with one week rest periods. Should be adjusted to individual requirements.
ALSO AVAILABLE: Milprem-400 (400 mg. Miltown + 0.4 mg. Conjugated Estrogens, equine) in bottles of 60 tablets.

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relief
from
emotional
and somatic
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of ovarian
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BLUE CROSS-BLUE SHIELD DISPUTE

waukee bunch is their pride, their damned, bullheaded pride," said a doctor sitting near the press table. And another chimed in: "This is a situation just like the one in Little Rock. One small area is defying the duly constituted authority."

A Legal Problem

Dr. Donald M. Willson, chairman of the Milwaukee delegation, rose to a point of order. "The authority of the state society is supreme in intramedical matters," he agreed, "but not in legal matters. The right to run

our Blue Shield plan was conferred on us by law. A motion to interfere with our running of it would be contrary to the state law and therefore out of order."

Lawyer Crownhart contradicted him. "Another portion of the state law says that a county society cannot adopt regulations contrary to the rules of the state medical society. This is a matter for this House of Delegates to determine."

"This House is not superior to the State Legislature," persisted Dr. Willson.

"That fellow's sure obsti-

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nate," someone said. "After all, Charlie's a lawyer."

"*Sit down!*" The shout echoed from several parts of the hall. Dr. Willson went back to his seat, and soon another Milwaukee M.D. spoke up. Dr. James Sullivan said the Milwaukee Blue Shield plan had gone state-wide because the state medical society's plan was too weak to compete effectively with commercial carriers.

It's Only Temporary

"As soon as we're convinced that W.P.S. is really on its feet

and has recovered from the management error of separating from Blue Cross," he promised, "we'll go back inside our own boundaries."

Charlie Crownhart requested the floor to speak in rebuttal. He spoke for seventeen minutes, winding up with:

"Wisconsin Physicians Service is in the black. Surgical Care and Blue Cross are not in the black. I think that proves we are operating effectively, even in a period of emotional competitive activity. Milwaukee is assisting Blue Cross in a planned pro-

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gram, the objective of which seems to be: *Rule or ruin!*"

Secretary Crownhart sat down to a round of applause. But Dr. Robert Purtell cut into it with these biting words:

"Our hired lay secretary has just completed seventeen minutes of oratory. May I request ten or twelve minutes of this House's attention?"

An embarrassed hush fell over the room. Dr. Purtell went on: "I am a member of the Blue Cross board. I have watched this fratricidal strife that has pitted doctor against doctor for eighteen years. This is a personal family vendetta.

'Killed His Brother'

"It's been said by our hired lay secretary that Blue Cross killed his brother.* I have two dead brothers. I submit that Mr. Crownhart's brother, like my two brothers, was taken by Divine Providence. I'm sick and tired of hearing Blue Cross blamed for everything!"

There were murmurs from the chair, but Dr. Purtell continued.

"Organized medicine, under

*George Crownhart, previous secretary of the Wisconsin State Medical Society, died of a heart attack in 1941, two years after a medical society altercation with Blue Cross.

the leadership of the two Crownharts, has done everything possible to disrupt and undermine Blue Cross. Why was the House of Delegates bypassed last May when the dissolution of the agreement with Blue Cross was in progress? I was told by members of the Council that it was done because the delegates wouldn't have understood the problem.

Resignation Invited

"The secretary secured approval of his strategy by telling a series of falsehoods. I say the greatest boon the secretary could offer Wisconsin medicine would be to resign!"

The House found its voice after a moment of shocked silence. A chorus of "Boos!" rang out. Dr. Purtell went back to his seat.

There didn't seem to be any answer to Dr. Purtell's speech. Some time after midnight, Dr. George Collentine Jr. of Milwaukee put the general feeling into these words:

"I think it's clear to everyone here that this dispute will be decided by a vote of 57 to 24. It's obviously the will of this House that Surgical Care withdraw

Patient J. I.
Duodenal Ulcer
before PATHIBAMATE



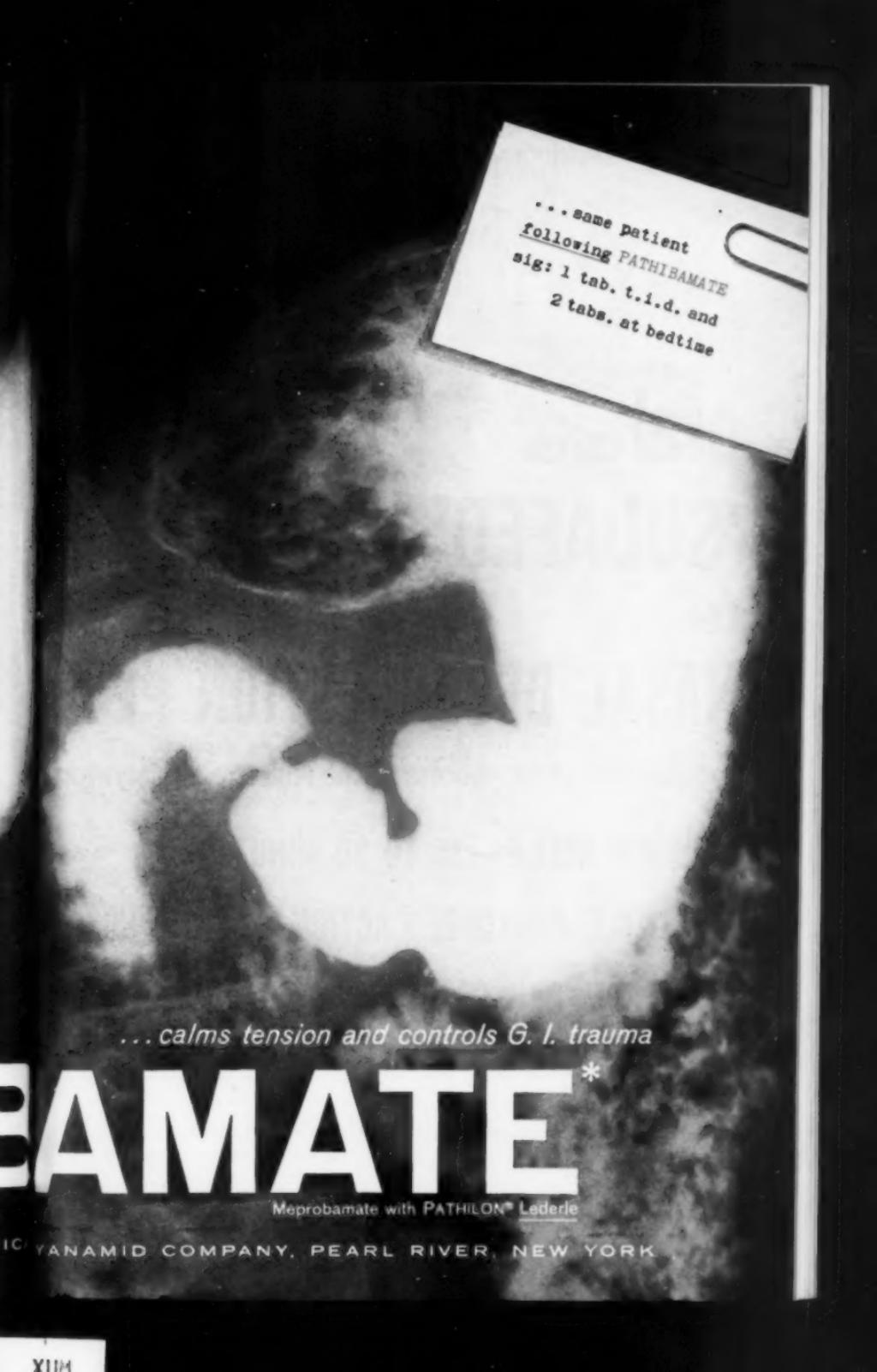
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from the state or that the two plans merge. It's late. We're all tired. Let's convene in the morning for the vote. Nothing we're saying now is going to change anyone's mind."

For the first time that night, a Milwaukee man was applauded.

Who Won

When the House reconvened the next morning, the vote went just about as young Dr. Collentine had predicted. It was a roll-call vote of 55 to 22, with four men not voting.

Thus, on Sept. 27, the Wisconsin House of Delegates issued an ultimatum to Milwaukee doctors to amend their bylaws so that they could not conduct any operation outside their county without formal consent and approval. They gave them a deadline of Jan. 1.

They further required that Wisconsin Physicians Service be the only Blue Shield plan in the state. The only place for Surgical Care would be as "a branch of the mother plan," operating within its own county. (No one bothered to argue that the "branch" was three years older and nearly 100,000 contracts bigger than "the mother.")

It was at this point that Dr. Jerry Fons of Milwaukee, current president of the state society, asked for the floor. By resigning his office, he at least gave Milwaukee men the last formal word. It was just about all they did get.

But there were informal words aplenty as the Milwaukee doctors rolled toward home in a big chartered bus with bar and bathroom. They sang "On Wisconsin" and old German songs to the accompaniment of Dr. William J. Egan's accordian. A Milwaukee Sentinel reporter sat up front, pecking at a portable typewriter.

They Expected It

"We weren't surprised we got clobbered," said one Milwaukee doctor. "Crownhart had been stumping the state, exploiting the natural city-country rivalry. We expected to be licked in this round. But our legal counsel says we're within our legal rights. They can take us to court if they want to, but they can't win."

And that's how things are in Wisconsin, the placid-looking land of unpredictable extremes that produced the LaFollettes and McCarthy.

END

'I'm a family doctor,' says this specialist. 'My patients are varied, and so is my work. The night call after a tough day is rare.' Here's his claim for ophthalmology:

'It's the Perfect Specialty!'



BY MALCOLM A. McCANNEL, M.D.

A couple of years ago, MEDICAL ECONOMICS made a study of career satisfaction among specialists. Only 63 per cent of the pediatricians it surveyed said they'd choose their specialty again if they were starting over. Reading toward the top of the list, I note that 78 per cent of obstetricians said they'd pick the same field again; 81 per cent of

surgeons; 82 per cent of internists; and 85 per cent of psychiatrists.

Actually, there's one specialty that would rate close to 100 on this satisfaction scale. It wasn't included in the aforementioned survey because it isn't one of the five largest. But it's the best—at least in its practitioners' almost unanimous view. Let me give

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Cautions: The precautions and contraindications that apply to all steroids should be kept in mind when prescribing PARAFON WITH PREDNISOLONE.

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'IT'S THE PERFECT SPECIALTY!'

you eighteen practical reasons why:

1. The ophthalmologist has patients in every age group.

Children can be a challenge, fun, and gratifying; but so can geriatric patients. The ophthalmologist sees them all. If he wants, he can even make appointments to see the children on one day, senior citizens on another, and mixed presbyopes on a third.

Bisexual Practice

2. He treats both sexes.

Ladies can be quite charming. But contemplating a day of practice with *only* the distaff side makes me blanch. By the same token, I'd dislike a post in military medicine, where I might have to treat men all day long.

3. He practices both medicine and surgery.

Diagnostic problems in ophthalmology are as varied as you'll find in any specialty today. And ophthalmic surgery is precise, gentle, and fast. Few procedures take over an hour. The surgery is primarily a solo performance, with its greater responsibility and its concomitant salve to the ego. A good result seems personally rewarding. Re-

moval of a cataract usually restores vision. A strabismus operation may eliminate a neurotic sense of inadequacy. We often get to see the happy results of our work.

4. Ophthalmology is clean.

You'll encounter very little smell, dirt, or other unpleasantness in my specialty—in contrast to most.

5. Ophthalmology is exact.

By the time an examination is finished, eye men generally know just what they're dealing with. The patient's pocketbook hasn't suffered materially because of X-rays or complicated lab tests. Our subject of study is directly before us. We can proceed in an orderly, logical manner to evaluate each patient's difficulty.

No Isolation for Him

6. The ophthalmologist is in touch with day-to-day living.

One of my pediatrician friends tells me that the very nature of his practice denies him a chance to find out what's going on in the community. In ophthalmology, the patients come in different sizes and types, so you get the feeling that you have your finger on the pulse of local politics, the construction that's under way

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I'd rather have a toothache



glasses even hurt my nose



they talk about sinus but



my hat weighs 50 pounds



throbs most when I bend over



throbs all day, could explode

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AVERAGE DOSAGE: *Adults:* Two tablets every four hours. Prophylactically, one tablet every four hours. *Children 6 to 12 years:* one-half adult dosage.

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'IT'S THE PERFECT SPECIALTY!'

down the street, the program at the high school last night, etc.

7. Ophthalmology is basically an office practice.

The eye doctor is far less at the mercy of the changing floor nurses than are his hospital-oriented colleagues. Since he spends the greater part of his working day in the office, he has a real incentive to plan, furnish, and decorate it. He can make it a pleasant environment for efficient work.

8. The ophthalmologist feels needed by other specialists.

Ophthalmology serves more branches of medicine than any

other specialty does. Hardly a week goes by that I don't see a patient with a chronic headache, sent by a neurologist; a cross-eyed child referred by a pediatrician; the internist's patient with a metabolic ailment; or some other colleague's referral. The base is so broad that no colleague has ever raised the ogre of fee splitting with me.

9. My colleagues and I are literally family doctors.

Not every specialist can say that. After our orthopedist friend sets Junior's wrist or nails Grandma's hip, and the bones knit, he usually has no further



"'Like hell' is a bit general . . . specifically, how do you feel?"



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*in the control of systemic infections
particularly those of the respiratory tract.*

MADRIBON

*introduces new standards
of effectiveness and tolerance*

*characterized by
rapid, prolonged blood levels
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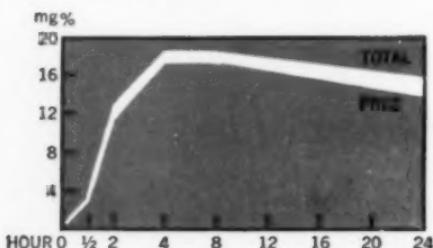
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Average blood level after administration of a single 2 Gm dose of Madribon.

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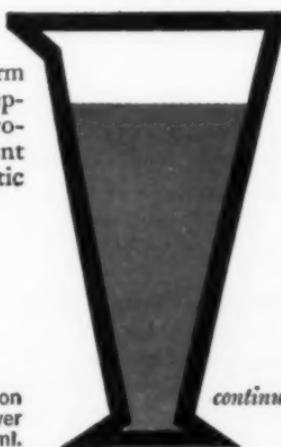
good or excellent response

poor response

side effects

Highly soluble

The glucuronide form of Madribon is exceptionally soluble—providing an important margin of therapeutic safety.



Solubility of Madribon
in the urine: over
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continued on next page ▶

in systemic infections, particularly those of the upper respiratory tract

new

MADRIBON

is realistic therapy

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*"The use of Madribon was very simple and there were no side effects or toxic reactions."*¹ Incidence of side effects (such as nausea or dizziness) to date is only 1.3% in more than 5000 Madribon-treated patients.

Usual Dosage: ADULTS: 2 tablets initially followed by 1 tablet daily thereafter.

CHILDREN:	Initially	Every 24 hours
20 pounds	1 teaspoonful	½ teaspoonful
40 pounds	2 teaspoonfuls	1 teaspoonful
80 pounds	4 teaspoonfuls	2 teaspoonfuls

Therapy should be continued for 5 to 7 days or until patient is asymptomatic for at least 48 hours. The above dosage should be doubled for severe infections requiring more intensive therapy.

Packages: TABLETS: 0.5 Gm, double scored, monogrammed, gold colored—bottles of 30, 250 and 1000.

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*W. A. Leff, Paper read at the New Jersey Chapter of the Am. Fed. Clin. Res., Newark, Sept. 17, 1958.



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'IT'S THE PERFECT SPECIALTY!'

contact with the family. But ocular needs stay with a person all his life. So the eye man gets to know sisters, brothers, grandparents, aunts, and uncles, as well as newborn babies. He follows the family as its members grow up and go away to school, take new jobs, marry, and have their own children.

The G.P.'s Friend

10. We get along well with general practitioners.

The oculist rarely steps on the general practitioner's toes. Many family doctors do their own refractions, and this is all to the good. Here the ophthalmologist can act as a consultant. Or else the G.P. may simply ask the ophthalmologist to "take over the family's eye needs."

11. We retain personal supervision of our patients.

Few specialists have as complete control over the patient's preoperative orders and his post-operative management as ophthalmologists do. There are very few poorly handled surgical cases to salvage (unless, of course, one reaches the enviable position of being a consultant to other oculists).

12. Ophthalmology isn't a so-

cially taboo topic of conversation.

No one's ashamed of his need for glasses. If, during a routine physical examination, a G.P. says, "I'm going to send you to an eye doctor," the patient takes it in his stride. Doctors themselves all realize how firmly established our specialty is. After all, the American Board of Ophthalmology was the first to come into being, decades ago.

13. The ophthalmologist keeps regular hours.

The wearying night call after a tough day is rare. Even the patient with a chronic degenerative eye disease and disabling loss of vision is usually ambulatory and can come to the office on his own. The occasional eye ailments that require immediate treatment in a hospital are always interesting enough to compensate for the trouble.

It's Interesting

14. He has little reason to get depressed or bored with his work.

Some specialists handle so many diseases of unknown etiology and uncertain prognosis that their work is depressing. Other doctors deal with such a

'IT'S THE PERFECT SPECIALTY!'

bulk of inconsequential complaints that they're beset with ennui. The work that comes the way of an ophthalmologist seems to strike a happy balance between those extremes.

15. *He can locate where he likes.*

Ophthalmology can easily be practiced in most communities that are too small to support any other specialty. Because there's a shortage of well-qualified eye men, a town of almost any size can take one in and provide him with a good living.

Opportunities Ahead

16. *Ophthalmology has a great future.*

New avenues have opened up for our specialty in the last ten years. New techniques and instruments—electromyography, radioisotopes, therapeutic adjuncts such as steroids, tranquilizers, and antibiotics—have changed the face of ophthalmology. Electroretinography, tonography, and qualitative perimetry too are fast-growing fields.

17. *Ophthalmologists get along well with one another.*

Our specialty's societies and study groups throughout the na-

tion are known for their sociability. Other specialty groups are copying the American Academy of Ophthalmology and Otolaryngology's idea of an annual meeting combined with post-graduate courses.

Some wit has suggested that we ophthalmologists are so comradely together because we're making inroads into the optometrists' appointment books rather than into one another's.

They're Not Too Busy

18. *It's easy for us to limit our workload.*

If an older ophthalmologist wants to cut down his work, or if a tremor or some other condition makes surgery impractical, he can still keep his hand in by doing office work only. It's easier for us than for most specialists to taper off and run by appointments the amount of work we want.

It's Ideal

In view of all the points I've made, you can surely see why I'm convinced that ophthalmology's contentment ratio is the highest. A doctor can't go wrong if he follows the precept: "Be wise. Choose the eyes." END

Pyribenzamine® EXPECTORANT breaks up cough



even persistent cough

Patient, factory worker, age 43, had suffered for months with persistent, dry cough, which he termed "smoker's hack."

Cough frequently interrupted his sleep, causing him to be nervous, irritable; his job efficiency was impaired.



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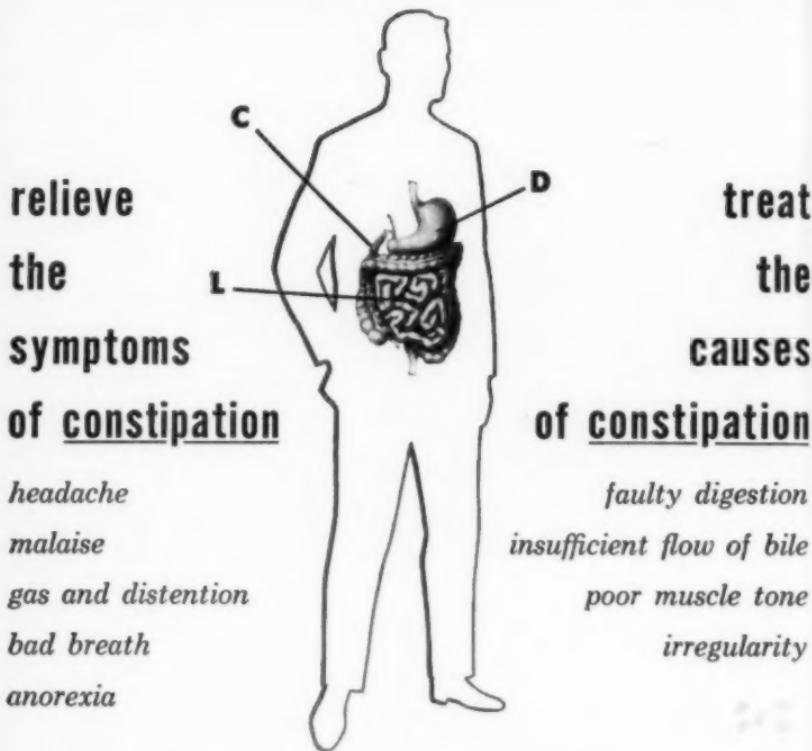
(1) Sturgeon, P.: Pediatrics 18:267, 1956. (2) Wallerstein, R. O., and Hoag, M. S.: J.A.M.A. 164:962 (June 29) 1957.

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make it a routine practice to have only "regular" patients



How Well-Managed Is Your Practice?

This self-test will help you evaluate your professional and business equipment. It's the sixth quiz in this series

By Horace Cotton

In surveying more than 100 medical practices in ten states, I found there was one sure tip-off to the doctor's attitude toward medical office efficiency. That was the age of his professional and business equipment.

If the equipment was pretty new throughout, the doctor almost invariably turned out to be keenly interested in doing the most for his patients with the least waste motion.

If the equipment was pretty old, it indicated the doctor didn't much care about putting time, money, and profes-

THE AUTHOR heads his own professional management firm, which has headquarters in Southern Pines, N.C., and offices in major cities throughout that state.

The Mentally Ill Can Come Back



Modern treatment can save them!
Help the thousands needlessly
confined in our mental hospitals!

**Give... LOCALLY TO THE
NATIONAL ASSOCIATION
FOR MENTAL HEALTH**

PRACTICE MANAGEMENT

sional skill to the best possible use.

In this self-test, I won't ask you about the age of your equipment. But I will say this: When you've depreciated something off the books, it's time to think about buying a new one.

The old one works fine, you say? Maybe so. But it's a fair bet that today's model is better. And don't imagine, Doctor, that your patient doesn't know the difference between your old examining table and the more modern job in that other office down the road. Why risk having your out-of-date equipment tag you as an out-of-date physician?

Now for four questions that get down to specifics. Ready with a pencil? Here's the first:

1. Do you have all the examining-room equipment you can use?

Yes

No

Not sure

If your answer is "Yes," think twice. Are your examining rooms identically equipped, so that instruments don't have to be carried from one room to another when you need them?

Don't let cost stop you. It may cost \$1,000 per examining room—but that's less than \$10 a



harmful cough—6 to 8 hours with one timed-release tablet

A single, easily-swallowed Tussaminic tablet provides decongestion of the upper respiratory tract, non-narcotic control of the cough reflex center and effective expectorant action.

Nasal and paranasal congestion associated with cough is relieved by the oral respiratory decongestant action of Triaminic®. Non-narcotic antitussive action is provided by Dormethan, as effective as codeine but without codeine's drawbacks. The classic expectorant, terpin hydrate, helps augment the flow of demulcent respiratory fluids.

Each Tussaminic Tablet provides:

TRIAMINIC®	100 mg.
(phenylpropanolamine HCl)	50 mg.
pheniramine maleate	25 mg.
pyrilamine maleate	25 mg.
Dormethan (brand of dextromethorphan HBr)	30 mg.
Terpin hydrate	300 mg.

Dosage: One tablet in the morning, mid-afternoon and at bedtime. The tablet should be swallowed whole to preserve the timed-release action.

how Tussaminic timed-release tablets provide 6 to 8 hours of cough relief

**first—the outer layer disintegrates
in minutes to provide 3 to
4 hours of relief**



**then—the inner core releases
its ingredients to provide
3 to 4 more hours of relief**

Tussaminic

*timed-release
tablets*

for relief from harmful cough "around the clock"

On one tablet—the patient
can work all day

On one tablet—the patient
can relax all evening

On one tablet—the patient
can sleep all night

*Triaminic will  running noses  and open stuffed noses orally

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska • Peterborough, Canada

HOW WELL-MANAGED IS YOUR PRACTICE?

month when depreciated over the life of the equipment. You come out ahead if the extra equipment lets you handle three additional office visits per month without additional effort.

If you checked "No" or "Not sure," just consider this: You're handicapping yourself as a physician if you don't have all the tools you need (which isn't the same as all the tools that arouse your interest in the catalogue).

I do *not* suggest that every fledgling G.P. should buy all the items a persuasive salesman has to offer. But I do say that doing

without a piece of equipment you need, solely because of its cost, can be the worst kind of economy. Economy doesn't mean *not* spending; it means *wise* spending.

2. Do you have all the special professional equipment you can use?

Basal metabolism

machine

Diathermy/ultrasonic

Electrocardiograph

Laboratory equipment

X-ray/fluoroscope

You're the judge of whether the

Rx
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WITH THE FIRST DAY'S DOSE

you'll see renewed vitality—even before you notice the "tonic" effect of ALERTONIC vitamin-mineral supplementation.

TRADEMARKS: "ALERTONIC," MERATRAN

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New York • CINCINNATI • St. Thomas, Ontario
Another Exclusive Product of Original Merrell Research

above items would be useful in your practice. If any would be, and if you didn't check the box, why not? Not trained to use the equipment? Then maybe you ought to consider getting yourself trained.

This doesn't mean you're ever justified in installing the equipment of a specialty for which you cannot be properly trained. That's bad management as well as bad medicine.

But if (to cite an actual case) the possession of a \$100 cast saw would save half an hour of your office time whenever you

used it, as compared with the chip-and-hack method, you'd be foolish to do without it. I know that a cast saw isn't anything like an X-ray machine, but it makes the point just as well.

3. How are you fixed for basic business equipment?

- Manual typewriter(s)** ...
- Electric typewriter(s)** ...
- Manual adding machine**
- Electric adding machine**
- Dictating equipment** ...

Machines cost less than man-hours or woman-hours. If you lack some of the business ma-

tonic

...BRIGHTEN THE OUTLOOK

TONIC alerts the listless, blue patient, brightens his outlook fast, contains a safe, effective psychic energizer.*

scription only. One tablespoon t.i.d. Professional literature and samples on request. Write Dept. AT

...NOURISH THE BODY

Supplementary B-vitamins and minerals give a needed lift to poor appetite and metabolism.

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Health Jour
located in

PEIZER
Glasses

In Chicago one feels the pulse of the nation's industry

It is crisscrossed by transcontinental railways, airways, and superhighways. Lakeport and seaport, it is a center around which trade and commerce move in ever-widening circles.

From the ashes of the great fire of 1871 arose this towering city of steel and stone. Chicago is the world's outstanding meat packer, home of the largest grain and livestock markets, and of a publishing and printing empire. From its factories pour iron and steel, machinery, electrical equipment, railroad cars and equipment, chemicals and textiles. Chicago was the scene of pioneer work in atomic fission.

Yet Chicago is renowned, too, as a center of the arts and other cultural pursuits...

The Chicago Symphony, the Art Institute, the Museum of Natural History, and such universities as Chicago, De Paul, and Loyola. Chicago is a city of contrasts... more than forty languages are spoken here... beautiful parks and gardens intersperse acres of industrial installations... and over twenty miles of fine beaches frame the shores of Lake Michigan.

"Windy City" with good reason

Chicago has long been known for its extremes of climate and rapid temperature changes. To experience those cold slashing winds roaring in from the lake in late fall or winter is to remember them... not to mention the head colds that may follow in their wake.

But don't worry about nasal congestion

In Chicago—as in other cities throughout the nation—you'll find an ample supply of TYZINE, the nasal decongestant for quick, long-lasting action. TYZINE is bland, entirely free from taste or odor, and with virtually no sting, burn, or rebound congestion. We suggest that you try TYZINE in the appropriate dosage form for your patients' nasal congestion due to colds or allergy. At this time, in most of these United States you're likely to run into this complaint—often.

nasal patency in minutes for hours

Tyzine®

brand of tetrahydrozoline hydrochloride

Nasal Solution, 1 oz. dropper bottles, 0.1%
Nasal Spray, 15 c.c. in plastic bottles, 0.1%
Pediatric Nasal Drops, in 1-2 oz. bottles, 0.05%,
with calibrated dropper.

Note: As with certain other widely used nasal decongestants, over dosage may cause dependence or over-sensitivity. Therefore, it is not recommended for use in CHILDREN OF ALL AGES. TYZINE Nasal Spray and TYZINE Nasal Solution, 0.1%, are not recommended for use in PREGNANT WOMEN. If you are using TYZINE Nasal Spray in the plastic bottle, it should be well stirred only in an upright position.

Pfizer

PRACTICE MANAGEMENT

chines listed above, you're not getting the work-output per employe-hour that you're paying for.

Is It Modern?

Do you have manual business equipment in your office? Take a close look at it. That ten-year-old typewriter, perhaps—they make better ones now. And that ancient hand-cranked adding machine—the new lightweight electrics cost less than you paid for Old Faithful, and they make the job go faster.

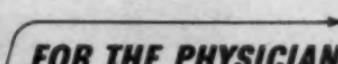
Are new business machines really worth the money? Well, consider dictating equipment. Let's assume that at present you dictate letters to your secretary, who takes them down in shorthand and later transcribes them on her typewriter. Let's say you pay your girl \$3,500 a year, which amounts to almost \$68 per week.

Save by Spending

Dictating-transcribing equipment with accessories will cost you about \$800. If, by using such equipment, *eleven minutes a day* of your girl's time can be transferred to other useful work, the machines are paying for themselves. If the saving is twelve minutes a day, the ma-

BREAKTHROUGH  **IN DIABETES**

BREAKTHROUGH  **FOR THE PATIENT**

BREAKTHROUGH  **FOR THE PHYSICIAN**

BREAKTHROUGH  **FOR METABOLIC INVESTIGATORS**

Upjohn

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THE ORINASE EPOCH

Freed from the encumbrances of needle syringe and sterilization, and freed from the tensions caused by worry about potential hypoglycemic reaction, the patient on Orinase can look forward to a more normal type of life in which his metabolic disorder is not complicated by the paraphernalia of injection.

For the newly discovered patient, the diagnosis of diabetes is no longer a commitment to a long sentence of

injections. Families of diabetics can now assume a more normal way of life, unimpeded by social and economic disabilities and the personal demands of the metabolic invalid. This new era has opened for the majority of diabetics. Those most responsive have had onset of diabetes after 40 years of age and, if on insulin, generally require less than 40 units daily.

"Orinase-responsive" patients, as a group, usually enjoy a superior quality of control. With Orinase, the management of diabetes is smoother, associated with a feeling of greater stability and well-being, and free from the danger of hypoglycemic shock. Patients are more cooperative and can assume occupations from

which hormonal therapy might disqualify them.

New diabetics are easier to indoctrinate and to manage. Mild diabetics, who either personally object to insulin or whose diabetes is so mild as to make one hesitate to add insulin to the regimen, are both excellent candidates for Orinase.

It has been shown that in the presence of a functional pancreas, Orinase effects the production and utilization of *native* insulin via normal channels. Its administration results in changes in fat and protein metabolism known to be the physiologic resultants of insulin activity. More recently, several investigations have demonstrated that the effects of Orinase upon hepatic glucose release are none other than those of endogenously produced or endo-

portally administered insulin. These observations have been followed by the further realization that the liver may play a primary physiologic role in the mechanisms of insulin action. Experience with Orinase suggests a classification of diabetics into two apparently distinct groups —Orinase-responsive or "Orinase-positive" diabetics, and "Orinase-negative" diabetics. It remains to be determined whether these will prove to be distinct clinical entities.

HOW WELL-MANAGED IS YOUR PRACTICE?

chines are making a profit for you.

4. Do you have all the special office equipment you can use?

- Bookkeeping machine** . . .
- Check-writer**
- Copying machine**
- Mailmeter**
- Mimeograph machine**

Here's one way to tell whether

you need some or all of the above:

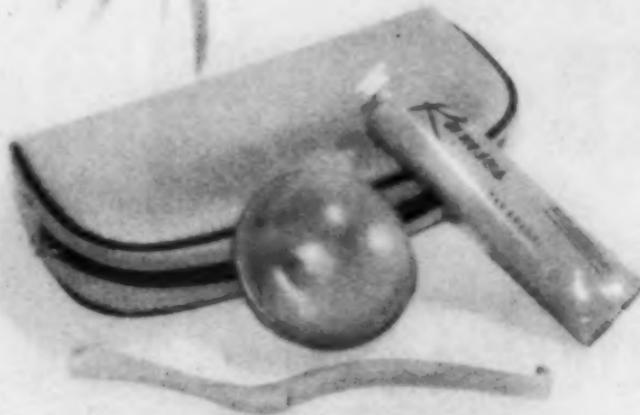
When your girl has some of yesterday's work on her desk each morning and when that bit of left-over work is growing day by day, ask yourself whether some new machine would give her the extra time she evidently needs. It could be a bookkeeping machine, a copying machine, or any of those listed above.

The difference such a machine



"He calls it an exploratory. For him, I'd call it a remunerative reconnaissance."

Patient cooperation assured—



when you prescribe the new RAMSES® "Tuk-A-Way"® Kit (no. 701)

Beauty and convenience—the new kit, designed for feminine appeal, is attractively finished, compact for traveling. The zipper now runs across the top and down the side, providing easier access to the contents.

Ramsey Diaphragm—cushioned comfort and optimal protection are ensured by the unique flexible rim, the strong, velvet-smooth dome.

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Ramsey Vaginal Jelly*—10-hour protection is provided by this nonirritating, nontoxic spermatoctide. Safe for continued use, cannot impair future fertility.

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NEO-SYNEPHRINE

Compound

Cold Tablets

offer "Syndromatic" Control
in the COMMON COLD, Allergic Rhinitis

Patients breathe, sleep, work and
play better with new "syndromatic" action.

Neo-Synephrine Compound Cold Tablets...
for... Full "Syndromatic" Relief.

Neo-Synephrine (brand of phenylephrine) and
Thenfadil (brand of thenylidiamine), trademarks reg. U.S. Pat. Off.

Neo-Synephrine COMPOUND Cold Tablets

protect patients through the full
range of symptoms

Each tablet contains:

NEO-SYNEPHRINE HCl, 5 mg.

Mild, long acting decongestive

controls

NASAL STUFFINESS, RHINORRHEA

relieves

Acetaminophen, 150 mg.

Effective analgesic and antipyretic

HEADACHE AND ASSOCIATED ACHES AND PAINS

neutralizes

Thenfadil® HCl, 7.5 mg.

Dependable, well tolerated antihistaminic

ALLERGIC SENSITIZATION

counteracts

Caffeine, 15 mg.

MENTAL AND PHYSICAL LASSITUDE

Dose: Adults—2 tablets three times daily.

Children 6 to 12 years—1 tablet three times daily.

Bottles of 20 and 100 tablets

Winthrop LABORATORIES
NEW YORK 18, N. Y.

HOW WELL-MANAGED IS YOUR PRACTICE?

can make is well illustrated by this case history:

A three-man group had 1,200 bills to get out every month. The job couldn't be done during regular office time without dislocating routine for several days. So the doctors paid each of three girls (secretary, nurse, technician) \$15 extra per month to do this job after office hours. The girls didn't like the overtime job, but it was better than a nervous breakdown every month-end.

Then the doctors bought a copying machine for \$300. They had new account cards printed

to suit the machine. Figuring in machine depreciation, extra cost of new account cards, etc., the switch-over added 2 cents to the cost of each statement sent out. But it took $3\frac{3}{4}$ cents off the labor cost, because the work is now done during regular office time.

So the doctors saved money; the girls got rid of an unwelcome overtime job; and the patients get bills that are itemized, accurate, and on time.

Is that the sort of efficiency you'd like in *your* office? If so, the equipment listed in this self-test may offer you the key. END

Compazine[®]

prochlorperazine, S.K.F.

the tranquilizer and antiemetic

proved remarkably safe and effective

in over $3\frac{1}{2}$ million patients

Smith Kline & French Laboratories

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A Summary Report on CORTROPHIN®-ZINC

(Corticotropin-Alpha Zinc Hydroxide)

Description: A unique patented electrolytic process (developed by Organon research) produces a complex of *alpha* zinc hydroxide and corticotropin. This complex offers considerable advantages for practical ACTH therapy.

Characteristics: New Cortrophin-Zinc provides corticotropin of unsurpassed purity with low foreign protein content. This reduces the risk of sensitization reactions.

Since about 5% of the corticotropin is uncombined, onset of clinical response is rapid. But the balance, present as a complex of *alpha* zinc hydroxide, provides a prolonged action so that the effective time span of a single dose is usually several days. Injection of the new electrolytic Cortrophin-Zinc is virtually painless.

Pharmacology: A potent stimulator of cortical activity, Cortrophin-Zinc does not depress functioning of the suprarenal glands. Unlike the corticosteroids, adrenocortotropic hormone arouses the adrenal glands to produce natural steroids in natural proportions. In a 5-year study of patients on ACTH therapy, no case of adrenal or pituitary depression or atrophy has been observed.

Because Cortrophin-Zinc is virtually painless on injection and its prolonged action obviates frequent injections, it is now practicable to use Cortrophin-Zinc in most of the indications where formerly reliance has been on corticosteroids. This freedom from apprehension of deleterious depressive effects permits clinical use of valuable hormone therapy on a broader scale than has been possible heretofore.

Clinical Uses and Dosage: The many published reports on the use of Cortrophin-Zinc as well as ACTH in thousands of patients indicate its value in over 100 disorders. Most responsive have been: allergies and hypersensitivities, rheumatoid arthritis, bronchial asthma, serum sickness, and inflammatory skin and eye diseases.

Dosage should be individualized, but generally initial control of symptoms is obtained with a single injection of 40 units of Cortrophin-Zinc daily, until control is evident. Maintenance dosage is generally 20 units (or less) twice a week.

Use of Cortrophin-Zinc with oral steroids is now recommended as a safety measure to supply the important suprarenal stimulation and lessen the hazard of atrophy. Periodic use of Cortrophin-Zinc is advocated with all steroid analogs, such as cortisone, hydrocortisone, prednisone, prednisolone, methylprednisolone, and triamcinolone.*

Supply: 5-cc vials containing 40 and 20 U.S.P. units of corticotropin per cc; 1-cc ampuls containing 40 and 20 U.S.P. units of corticotropin, with sterile disposable syringes.

*Write for complete literature and bibliography containing specific dosage schedules to:

Medical Department
ORGANON INC. • Orange, N. J.

in
peptic
ulcer

stop
the
pain

start
the
repair

KOLANTYL

1. **vital antispasmodic action**—
BENTYL—Merrell's fast, safe anti-
spasmodic . . . relieves spasm-pain
promptly, without atropine-like side
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aluminum hydroxide—prompt, long-
lasting relief . . . no laxation, no
constipation. 3. **demulcent action**—
Methylcellulose—soothing protective
coating covers ulcerated area,
promotes healing. 4. **antienzyme-
antipepsin action**—Sodium Lauryl
Sulfate—effectively curbs necrotic

with 4 needed
healing actions

effects of pepsin and lysozyme . . .
prevents further erosion. **Dosage**—
Gel: 2 to 4 teaspoonfuls every 3
hours, or as needed. Tablets: 2 tab-
lets (chewed for more rapid action)
every 3 hours, or as needed.

NON-CONSTIPATING . . . NON-LAXATING



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TRADEMARKS: "BENTYL," KOLANTYL®

What Social Workers Can Do For You



Here's how one doctor learned that, far from being 'socialistic' or competitive, they offer medical men some really helpful services

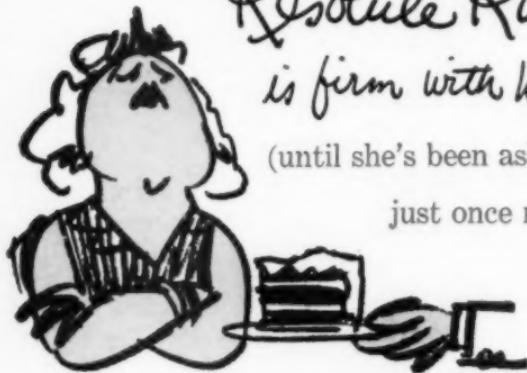
By Agatha Hopkins, M.S.W.

"One trouble with you social workers," the chief of staff told me, "is that in trying to help patients you sometimes make arrangements that come pretty close to being treatment. Another is that you favor the Forand bill and other forms of socialized medicine."

"One thing at a time, Doctor. We make arrangements for treatment only under a doctor's orders. Can you give me a for-instance?"

"Well . . . how about this Hackett child? I said he ought to spend the summer at a camp. Your office ar-

THE AUTHOR is director of the social service department of a large Eastern hospital.



(until she's been asked
just once more!)

You can help sustain the reducer's wavering will...

just one **PHANTOS®** capsule
DAY-LONG ACTION

provides day-long appetite suppression and mood elevation.

PHANTOS helps counteract the constipation and bedtime wakefulness which so often complicate reducing regimens.

Each PHANTOS capsule is constructed with a built-in timetable to release three separate sets of components at intervals which provide day-long action . . . eliminates the "forgotten" dose.

- **ALL RELEASES**—appetite control and mood elevation
- **IMMEDIATE RELEASE**—aloin to counteract constipation
- **FINAL RELEASE**—phenobarbital to offset evening excitation

IMMEDIATE RELEASE provides  Amphetamine Sulfate 5 mg.
Thyroid 1/2 gr.
Atropine Sulfate 1/360 gr. *counteracts
*Aloin 1/4 gr. morning constipation

INTERMEDIATE RELEASE provides  Amphetamine Sulfate 5 mg.
Thyroid 1/2 gr.
Atropine Sulfate 1/360 gr.

FINAL RELEASE provides  Amphetamine Sulfate 5 mg.
Thyroid 1/2 gr.
*Phenobarbital 1/4 gr. *relieves evening excitation

DOSE: one capsule on arising SUPPLY: bottles of 30, 250 and 500

FRANKAY LABORATORIES, INC., Harrison, New Jersey

WHAT SOCIAL WORKERS CAN DO FOR YOU

ranged four weeks at the Happy Time Camp run by the Orthopedic Hospital. When I say 'summer,' I mean 'summer'—not just four weeks."

I looked that one up. Well, the Hackett boy has cerebral palsy. The Hacketts live on a marginal income. They never whine about their financial standing to the doctor; somehow they always scrape up the money to pay his bill. But they can no more raise the \$500 for a special camp than I can pay off the U.S. Treasury deficit. So they'd asked us for help.

Better Than Nothing

The only suitable deal that we could arrange was the Happy Time Camp for orthopedically handicapped kids. Even that was supposed to be strictly a two-week hitch, but we pressured the camp people into doubling the time allowance just this once. If the Hacketts had had no social worker interested in the case, the child would have spent the entire summer in his small backyard.

That reminded me of the Anderson case. Mr. Anderson had ulcers; he also had an interesting and responsible job. Our gastroenterologist and our psychiatrist

went into a huddle about Mr. Anderson. They concluded that the tensions involved in his work were keeping the ulcer alive. Their solution: change to a less tense job.

He Saw Only One Side

Medically, I'm sure, that was sound advice. But the gastroenterologist, at least, hadn't given a second thought to such matters as the prestige value of a responsible job, the lower income of a less responsible one, and the effect of such a job change on the patient's family relations and living standards.

The psychiatrist thought of all that, but he was only a consultant. His chore was done when he sent a report to the internist explaining how Mr. Anderson's vocational worries were aggravating the ulcer.

'Third Party'

Social Service referred the patient to a vocational guidance counselor. Between us, we worked out a feasible plan all right. But to this day, the gastroenterologist grumbles about the interference of a "third party" in the doctor-patient relationship.

I told the chief of staff about

Cerofort

POTENTIATES TISSUE PROTEIN SYNTHESIS

Critically
essential L-lysine
with all the
important vitamins

tablets

To speed
convalescence
in major
surgery, illness,
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Efficient protein synthesis depends upon an adequate intake of proper proportions of all the essential amino acids simultaneously. The biological value of cereal proteins, which comprise 20% to 40% of total dietary proteins, is limited by a relative deficiency of lysine. Cerofort supplies physiologic amounts of L-lysine to raise the body-building value of many cereals to that of high quality protein. In addition, Cerofort Elixir supplies generous amounts of important, appetite-stimulating B vitamins. Cerofort Tablets provide therapeutic levels of all known essential vitamins. In order to obtain the optimal benefit of lysine supplementation, administration with meals is essential.

DOSAGE: 1 Tablet
t.i.d. with meals.
Cerofort Tablets
in bottles of 60.

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first with lysine

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Critically
essential L-lysine
with B vitamins

elixir

To improve
nutrition in
the elderly,
the adolescent,
the growing child

DOSAGE: 1 tsp. t.i.d.
with meals.
Cerofort Elixir
in bottles of 8 oz.

WHAT SOCIAL WORKERS CAN DO FOR YOU

the Hacketts and the Andersons. He nodded sagely—and then began needling me about social workers' "preference" for compulsory health insurance. Maybe he thought that the word *social* in our title has something to do with socialism.

Well, it's true that we social workers do have convictions about desirable social legislation. Just as doctors have—and should have—opinions about proposed laws affecting medical care. But I hastened to point out that every social worker I know goes to her own personally selected private

physician when she herself is sick. We know all about the value of a personal doctor-patient relationship.

I don't know of a single large social-work organization that has registered a definitive opinion in favor of state medicine. It's true, though, that some individual social workers look with a kindly eye on the possibility of changes in the method of financing medical care. I'll tell you why:

We constantly run up against persons who aren't willing to accept the stigma of charity, yet who aren't able to pay for long-



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really saves me work . . .

In just minutes, I get a complete financial picture of my practice
... day by day . . . every day.

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Address _____

SOCIAL WORKERS

term illness—the kind that runs on long after health insurance benefits have been exhausted. I'm no economist and no politician. But it seems to me that the medical profession, which has produced so many geniuses, should be able to work out some way of meeting such needs.

Doctors Aren't Perfect

I know that some physicians have a grievance against social workers. We, too, have some gripes about doctors—mild complaints that need not sour our relationship. Trouble is, doctors never ask us what bothers us about our work with them.

For one thing, we resent being

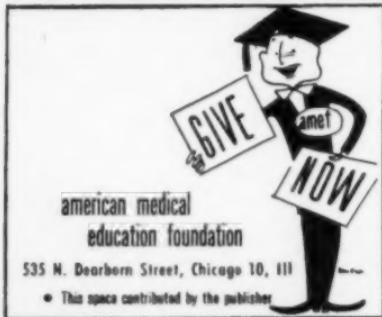


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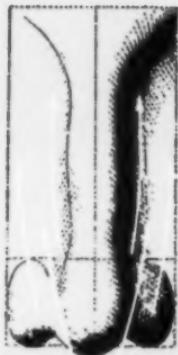
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Penetration is the prerequisite for sound intranasal therapy. Thonzonium bromide, an exclusive mucolytic agent with unusual penetration-promoting properties, causes prompt dispersion of mucoid secretions and speeds medication to the site of irritation. Deep infiltration also allows the therapeutic agents of Biomydrin to remain active for prolonged periods. Biomydrin lets the patient breathe easily again.



Biomydrin gives lasting relief of rhinitis or sinusitis in minutes. Phenylephrine shrinks nasal mucosa; antibacterial neomycin and gramicidin fight infection; antihistaminic thonzylamine relieves allergic itching and sneezing.

Supplied in 1/2 oz. plastic atomizer and 1/2 oz. bottle with dropper. Also available: Biomydrin F Nasal Spray, containing hydrocortisone alcohol 0.02%, for severe edema and inflammation. In 1/2 oz. plastic atomizer.

Biomydrin®

nasal spray/drops



- prompt, aggressive antibiotic action
- a reliable defense against monilial complications

both are often needed when bacterial infection occurs



for a direct strike at infection
Mysteclin-V contains tetracycline phosphate complex

It provides a direct strike at all tetracycline-susceptible organisms (most pathogenic bacteria, certain rickettsias, certain large viruses, and *Endamoeba histolytica*).

It provides the new chemical form of the world's most widely prescribed broad spectrum antibiotic.

It provides unsurpassed initial blood levels — higher and faster than older forms of tetracycline — for the most rapid transport of the antibiotic to the site of infection.

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Squibb Quality — the Priceless Ingredient

Capsules (250 mg./250,000 u.), bottles of 16 and 100.

Half-strength Capsules (125 mg./125,000 u.), bottles of 16 and 100.

Suspension (125 mg./125,000 u. per 5 cc.) 60 cc. bottles.

Pediatric Drops (100 mg./100,000 u. per cc.). 10 cc. dropper bottles.



for protection against monilial complications

Mysteclin-V contains Mycostatin

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WHAT SOCIAL WORKERS CAN DO FOR YOU

considered soft-hearted and soft-headed Lady Bountifuls. We think physicians should know that social workers for the past two decades have been concerned not exclusively with the poor, the misfits, and the underprivileged. Today we're asked to help solve problems found in all segments of society: marital difficulties, disturbed parent-child relationships, personal adjustment problems, and the like.

They're 'Professionals'

Professional social workers today are skilled counselors at the

master's-degree level. We don't expect to be treated as doctors' colleagues. But we'd like to be accepted as professionally trained staff members serving on a professional team.

Wasted Resources

Our most serious problem, though, is that doctors so seldom think of using the community resources we're trained to tap. In theory, every doctor knows that the patient isn't an isolated individual, but is part of a family and community setting; that physical or mental illness often affects the

Satisfied with the usual cough remedies?



- do you find that the local soothing effect of cough syrups is not enough?
- are you concerned about the side effects of codeine?
- do you find that many remedies decrease cough productivity?
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C I B A
SUMMIT, N. J.

1. Shane, S. J., Krzyski, T. K., and Copp, S. E.: *Canad. M.A.J.* 77:600 (Sept. 15) 1957.

SUPPLIED:
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family's pattern of living; that fears, anxiety, and debts can upset previous family harmony. But in practice, physicians seldom call on the social worker to ease environmental strains that may retard medical recovery.

We know our community's resources. That's why, more often than you probably think, we can help you help your patients.

Examples, Please

That's what I was telling the chief of staff when he lifted his hand in a stop signal. "Sounds wonderful," he said. "But in

plain English, what community resources are you talking about?"

I started to tell him about the woman who was worried about how her household would be managed while she was convalescing. I explained how we speeded convalescence by getting an agency to send in a trained home-maker. And how this service enabled a young widow to enter the hospital for a necessary operation, assured that the home life of her elderly parents would not be disrupted.

But the chief of staff wanted to see a list of the community re-

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WHAT SOCIAL WORKERS CAN DO FOR YOU

sources I was talking about. So I ran through the local Community Services Directory.

Here's a partial roster of the problems with which various social agencies are prepared to cope. No one agency offers all the services listed. But in most urban and suburban communities, there's usually some agency for each of the following:

- **ADOPTIONS:** Children studied and selectively placed in homes for adoption.

- **AGED:** Nursing homes; recreation centers; low-cost housing; old-age assistance.
- **BLIND:** Home instruction; talking-book machines; financial assistance; job placement.
- **BUDGETING:** Advice and assistance; consultation on food and nutrition.
- **CAMPS:** Resident and day camps for healthy youngsters; camps for the handicapped, retarded, and underprivileged.
- **CHILDREN'S SERVICES:** Resi-



"My arthritis is killing me. Let's go to the staff meeting and disagree with everything."



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WHAT SOCIAL WORKERS CAN DO FOR YOU

dental treatment of the disturbed; classes for the retarded; aid to the dependent; help with personality disorders.

● **CHRONICALLY ILL AND HANDICAPPED:** Homes; nursing care; homemaker service; educational training; special workshops; rehabilitation.

● **CITIZENSHIP:** Special services to foreign born; financial assistance; housing; health care; immigration help; education and Americanization.

● **DAY NURSERIES:** Daytime group care for children of working mothers.

● **EMPLOYMENT AGENCIES:** Vocational guidance; counseling in regard to employment; selective job placement of physically and emotionally handicapped; help in processing claims for unemployment and disability insurance.

● **FAMILY SERVICES:** Help with personal relationship problems, with economic and environmental difficulties, and with emotional disorders.

● **FINANCIAL ASSISTANCE:** Public assistance for living expenses; medical services and supplies; aid to dependent children; Federal disability assistance; aid to needy blind.

● **FOSTER HOMES:** Where children may live healthy, normal lives.

● **HOME MAKER SERVICES:** Specially trained women whose job it is to provide continuity to family life during periods of a parent's acute illness or absence from home.

● **HOUSING:** Processing of applications for Federally subsidized housing for low-income families.

● **LEGAL AID:** Advice and legal services to those who cannot afford an attorney.

● **MENTAL HEALTH:** Agencies for education, research, use and development of psychiatric facilities.

● **NEIGHBORHOOD CENTERS:** Educational and leisure-time activities for different age groups.

● **NURSING SERVICES:** Bedside care in the home, regardless of ability to pay; education in disease prevention.

● **PROSTHETIC APPLIANCES:** Help in renting, purchasing, or learning to use prosthetic appliances.

● **PSYCHIATRIC CLINICS:** Help in getting diagnosis and treatment of personality disorders of children and adults.

● **REHABILITATION:** Physical restoration; vocational retrain-

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for your many patients requiring
potent analgesia but not an injected narcotic

*Proved by extensive evaluation^{1,2,3} in 1998 patients
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Philadelphia 1, Pa.
1. Cass, L. J., et al.: J. A. M. A. 166: 1829 (April 12) 1958.
2. Batterman, R. C., et al.: Am. J. M. Sc. 234: 413
(Oct.) 1957. 3. Medical Department, Wyeth: Final
Report on the Clinical Evaluation of Zactirin.



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*Tebrock, H. E., et al, N. Y. State J. Med. 57: 101; 1957.

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WHAT SOCIAL WORKER CAN DO

ing; job placement for physically and mentally incapacitated.

• **SPECIAL SCHOOLS:** Classes for retarded, blind, deaf, physically or emotionally impaired.

• **TRANSIENTS:** Temporary shelter, food, clothing for homeless; work program.

• **TRAVELERS' AID:** Information regarding housing; travel service for children and the handicapped.

• **UNMARRIED MOTHERS:** Help in getting maternity care, financial assistance, temporary boarding of babies, adoption.

• **WIDOWS:** Help in obtaining survivors' insurance, employment; counseling to ease problems of adjustment.

When I handed the above list

Fight Mental Illness



**National Association
for Mental Health**

to the chief of staff, he put on his reading glasses and looked at it. He didn't say anything, but he did put it in his pocket. The next day, it was posted on the staff bulletin board.

It Opened His Eyes

Later, he came back and said that, while he'd been in practice thirty years, he'd never known the community *had* so many resources.

Then he added:

"It seems to me every doctor must meet up with some patient almost every day who could be helped by these community resources. This is a handy checklist. Merely reviewing it gave me some ideas on how to expand my own usefulness to patients."

"Not that I'm completely sold on having you social workers around. I still don't understand how these community agencies were built up without doctors' having a greater share in their development. But I'll admit that maybe—just maybe—you have something here."

Taking care of the patient requires teamwork. The social worker has a place on the line. We don't expect to call the plays. But we like to feel that the quarterback has some idea of what we can do.

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Dr. Kris' \$1,500 bill for saving a boy's life stirred up the whole nation last year. Now that the hubbub has subsided, the doctor explains why he still thinks the fee was fair. 'How much would you charge for 100 hours spent on a case where the family's well able to pay?' he asks. Here's the untold story of...

THE DOCTOR



WHO CHARGED TOO MUCH

By John R. Lindsey

"Sure, that bill of mine got a tremendous amount of bad publicity. But it was the publicity that was bad, not the bill. I set the fee after consultation with my colleagues, including medical society officers. They thought it was entirely reasonable—until the headlines and the higher-ups in medicine made them back down on professional principles."

Dr. Joseph Kris was talking about the \$1,500 fee that made front-page news more than a year ago. As you no doubt remember, the doctor played a major role in the dramatic (and much-televised) rescue of a 7-year-old Long Island boy from the bottom of a twenty-one-foot dry well. For twenty-three hours, Anesthesiologist Kris administered oxygen to the youngster wedged deep in the sand-filled pit. Credited with saving the child's life, he was on his way to becoming a national hero—until he submitted his bill.

Overnight, the hero became a "villain." Laymen and doctors alike subjected him to a storm of criticism for having dared to ask \$1,500 for his services. Public

and medical opinion forced the mediation committee of his local medical society to cancel the doctor's bill.

That was last year. How does Dr. Kris feel about the experience now? To find out, I arranged an interview with him not long ago. On the morning of our appointment, I rang the office bell, at one side of the plain white house in which he, his wife, and his daughter live in Eastport, Long Island, N.Y. The doctor himself opened the door and ushered me into his office.

Then, before I'd had a chance to do more than mention my name, he surprised me by saying: "May I see your credentials to prove you are who you say you are?"

Later, seated at the desk across from him, I understood why he'd wanted to be sure of my identity. Who had a better right to ask for identification than a man who'd been so persistently badgered day and night by reporters and photographers from press and television?

"I don't think you can realize what a horrible nightmare I lived

THE DOCTOR WHO CHARGED TOO MUCH

through," he explained. "Like any doctor, I sent what I felt was a reasonable bill to the parents of a young patient. Next thing I knew, everybody in the country was calling me a seven-headed monster. Why? Not really be-

cause of the fee, but because the press, radio, and TV had turned the case into a sentimental holiday."

He reached into a cabinet and brought out two outsize, stiff-backed portfolios, bulging with

WHERE DR. KRIS WENT WRONG

"I believe that doctors should report their failures as well as their successes," says Dr. Joseph Kris. "Then others won't fall into the same errors." Here are three mistakes he thinks he made in the realm of professional and public relations after spending 100 hours saving Benny Hooper's life:

1 "Although I sought the advice of medical society officers before sending a bill, I didn't get their advice in writing. So I couldn't prove that I'd acted in accordance with their advice."

2 "When a reporter came to me and said he wanted the people to know my side of the story, I told it to him. That was another mistake. My words were twisted to mean exactly the opposite of what I'd said."

3 "When I appeared before the medical society's mediation committee, I didn't have a lawyer with me. There was no one to protect my constitutional rights when the specified procedure wasn't followed."

But the biggest mistake of all, Dr. Kris believes, was the mediation committee's complete cancellation of his bill. He explains why in the accompanying interview.

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THE DOCTOR WHO CHARGED TOO MUCH

papers. "Here you are," he said, placing the volumes on the desk. "Here's my documented record of what happened."

I began leafing through the pages. In addition to a neatly typed account of the doctor's side of the controversial-fee story, they contained a vast collection of newspaper clippings and photocopies of letters.

"Those letters aren't the only ones I got," said Dr. Kris. "I got more than 1,000 from strangers in every part of the country. Only 250 are included in these volumes. But they're a representative sample. Take a look at them."

I opened a portfolio at random, and my eye lighted on these words: "You have the heart of a crocodile and should be kicked out of the medical profession." The letter had been written by a retired Army colonel in Corpus Christi, Tex. But I noted, to my surprise, that it was followed by another entry from the same man. Dated three months later, the second letter said: "In reference to your letter of recent date, to you I send an apology."

"Do you mean to say you *answered* that first insulting note?" I asked.

"I answered every letter that was signed," the doctor replied.

He pointed to a typed entry in one of the scrapbooks: "Received 694 unfavorable letters so far, 80 per cent of them anonymous. Of the balance, I've answered every one."

About half the correspondents acknowledged his letter. And, like the Texas colonel, some 70 per cent of these apologized, according to the doctor.

Headlines Fade Fast

"Another 10 per cent denied they'd ever written me in the first place," he observed. "Such is fame, I guess. People forget the big news stories fast. But it's not so easy for us who've *been* the stories to forget. Just glance at some of these headlines, will you?"

One in particular caught my attention: "A.M.A. Hits \$1,500 Bill for Benny."

Under it appeared a statement signed by Dr. Edwin S. Hamilton, chairman of the Association's Board of Trustees. "The A.M.A. feels . . . that not one doctor in a thousand would have charged a fee," it said in part.

In another news clip, Dr. Elmer Hess was quoted as calling

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...PENTIDS "400" ... PENTIDS "400" ...

New convenient oral tablets ... PENTIDS "400" ... Economical ... where double strength Pentids is required for treatment of severe infections due to *Staphylococcus* ... *Hemolytic Streptococcus* ... *Pneumococcus*. Also indicated for prevention of streptococcal infections when there is a history of rheumatic fever. PENTIDS "400" ... Squibb Penicillin G Potassium 400,000 Unit Tablets (Buffered) ... Dosage: 1 tablet t.i.d. without regard to meals ... Supply: Scored tablets—bottles of 12 and 100.

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THE DOCTOR WHO CHARGED TOO MUCH

the fee "absurd." Dr. Paul Hawley, I noted, termed it "a terrible thing." And the matter was even brought up on the U.S. Senate floor, where Senator William A. Purtell of Connecticut denounced the doctor who "must exact the last pound of flesh from the practice of his profession."

I looked up from the scrapbook. "How do you feel about such comments as these?" I asked.

"It's the ones from my own colleagues that bother me," said

Joseph Kris. "Why did they make statements to the press without knowing the facts of the case? I'd like to know whether Drs. Hamilton, Hawley, or Hess ever worked 100 hours on a case without sending a bill."

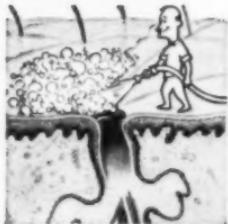
"A hundred hours?"

"I put in more than 100 hours caring for Benny Hooper both at the scene of the rescue and in the hospital for the next seven days. I made that fact clear at the time. But facts couldn't stand up against publicity." *More►*



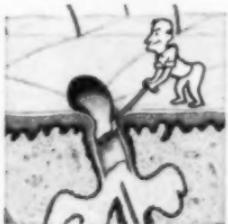
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Fostex dries and peels the skin

- ◀ The Sebulytic base of Fostex dries and promotes peeling of the skin . . . actions enhanced by the keratolytic effects of micropulverized sulfur and salicylic acid.

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for maintenance therapy to keep skin dry and substantially free of comedones.

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REFERENCES: 1. Flippin, H. F.: Virginia M. Month. 82:435, 1955. 2. Caswell, H. T. et al.: Surg Gyn Obst. 106:1, 1958. 3. Nesbitt, R. E. L. Jr., and Young, J. E.: Obst. Gyn., N. Y. 10:89, 1957.

in 7 years—negligible development of
bacterial resistance with FURADANTIN

NITROFURANS . . . a new class of antimicrobials . . .  neither antibiotics nor sulfonamides

THE DOCTOR WHO CHARGED TOO MUCH

At this point in our interview, Dr. Kris was called out to see a patient. Left alone with the two-volume scrapbook, I refreshed my memory on what had finally happened in the Kris case:

On June 22, 1957, the mediation committee of the Suffolk County Medical Society decided there'd be no bill. After conferring first with Dr. Kris, and then with Mr. and Mrs. Benjamin K. Hooper, young Benny's parents, the committee issued a formal statement upholding the right of "any doctor to render a bill."

But, the statement added, Dr. Kris "had determined the amount of his charge while under the mistaken impression that a considerable sum of money earmarked for medical purposes had been received by the Hooper family . . . In view of the facts . . . the committee has therefore decided, and Dr. Kris has agreed, that there will be no bill to the Hoopers."

I was examining a news photo of Dr. Kris shaking hands with the boy's father—"after the doctor's bill was written off," according to the caption—when the doctor rejoined me. He glanced over my shoulder, then said:

"That picture was taken be-

fore the mediation committee meeting, not *after*. I didn't shake hands afterward. I never agreed to accept the decision to cancel."

This was news to me. "Do you mean the \$1,500 bill still stands as far as you're concerned?"

"Yes," said Dr. Kris. "And you can quote me on this: I did *not* agree to withdraw the bill. It isn't a matter of money. It's a question of principle."

How He Set the Fee

Then Dr. Kris told me the story of how he'd set his fee in the first place:

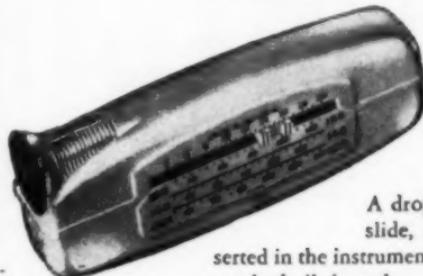
"After I'd taken care of the Hooper boy but before I'd submitted a bill, there was a hospital staff meeting. Talking with colleagues afterward, I brought up the question of whether any bill should be sent. They all agreed a bill was in order. And they suggested amounts ranging up to \$3,500. It was also suggested that the bill be made large enough so that it could be reduced later on if the family objected.

"Then at the next meeting of the Suffolk County Medical Society, I sought out the chairman of the mediation committee. I discussed with him the pro-



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*Complete bibliography available on request.

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HE CHARGED TOO MUCH

priety of sending a bill. 'By all means, you should send a bill,' he told me.

"I asked his advice on how to arrive at a fair fee. 'I can't figure the bill for you,' he answered, 'but I'll give you an example.' And he told me about a case on which he'd been called out of town. He'd spent a whole day in travel and treatment, and, he told me, he'd charged \$400 for that day.

Eight Times \$400

"If one day's services could be worth \$400, eight days' services could be worth more than \$3,000. That would correspond roughly to what my time is worth as an anesthesiologist—\$30 an hour for 100 hours. But with Benny Hooper, I wasn't acting as an anesthesiologist—just as a physician. So I cut the suggested rate in half and settled on \$1,500 as being fair."

"Could the Hoopers really afford to pay that much?" I asked Dr. Kris.

"Look at the record," he said. "They got at least \$3,345 from television appearances and well-wishers. And they weren't poor to start with. Their combined take-home pay came to at least \$108 a week—and this in a community where the average farm



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THE DOCTOR WHO CHARGED TOO MUCH

family makes \$56 a week and supports four children on it."

"Then why did the mediation committee cancel your bill?" I asked.

"They were being told how to 'work this thing out' by state and national medical society officials who didn't have the facts. Let me tell you how I know:

"When I met with the mediation board on June 22, 1957, I asked them to investigate both sides thoroughly, even if it took two weeks. Then they went into closed session. They wanted the executive secretary in with them; and she asked me if I'd answer the office phone in her absence, since I was going to be waiting anyway. This I agreed to do.

"Among the incoming calls were several from the New York state medical society and from the A.M.A. Their public relations people were trying to direct our mediation committee's verdict. And the verdict went their way within two and a half hours—and without any further investigation of the facts.

"I'm not against good public relations. All along, I've been a member of my medical society's public relations committee. I was mindful of this when I spent 100

hours in continuous attendance on the Hooper boy, to the neglect of my practice, my family, and my health. I was mindful of good public relations when I consulted with my medical society colleagues before submitting a bill.

"But what kind of public relations is it when a doctor's bill is canceled just because he saved the patient's life?"

"You never consented to the bill's being canceled?" I asked Dr. Kris once again.

Why He's Fighting

"No. And the mediation committee acted illegally in canceling it without my consent. No complaint was signed against me, as required by the bylaws; nor was the specified mediation procedure followed. That's why, as far as I'm concerned, the bill still stands."

As we shook hands at the door, the doctor repeated something he'd said before: "It's a matter of principle. Please make sure your readers understand that. I don't need money. My practice hasn't suffered from the bad publicity; I'm as busy as I ever was. But I feel I got a raw deal. And I'm going to fight till I'm vindicated."

END

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Quiactin for quieting

(one 400 mg. tablet q.i.d.)

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1. Proctor, R. C., Southern Psychiatric Assoc. Meeting, October 7, 1957. 2. Feuss, C. D. and Gratz, L. Jr.: Dis. Nerv. Sys. 18:29; 1957.

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QUIACTIN provides greater tranquility, yet avoids the drowsiness that causes patient discomfort or oversteps the bounds of safety.¹ Work, and other normal activities, continue with no drop in efficiency.² Structurally, QUIACTIN is a glycidamide... atom by atom, a completely new tranquilizer, prolonged in activity, non-toxic, noncumulative and free of withdrawal symptoms. QUIACTIN will not deepen depression if it is present.



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Stockbrokers' Commissions:



HOW TO KEEP THEM DOWN

With rates higher than ever, you'll want to watch your step when buying stocks. Here's how commissions are figured, and how you can cut the cost

BY M. J. GOLDBERG

One afternoon last summer, a Chicago physician I'll call Andrew Wilcox visited the office of his stockbroker to fulfill an old ambition. He wanted to have a fling at "tape reading"—investing for small, quick profits on the daily or weekly turns of the market.

For days he'd been studying a

stock called Great American Gadget as it jiggled around between \$40 and \$41 a share. And he'd begun to wonder: Why not make a quick profit by buying the stock at 40 and selling it the minute it rose to 41 again?

So that's exactly what Dr. Wilcox did on his summer afternoon off. When he entered the broker's

*Intravenous blood levels
with rectal administration*

CLYSMATHANE[®]

(Fleet)

Disposable Rectal Unit

*An advanced method of
theophylline therapy*

For the alleviation of symptoms in bronchial asthma and the acute episodes of heart failure, Clysmathane (Fleet) supplies speedy and therapeutically adequate blood levels⁽¹⁾ of theophylline. Side effects, often associated with oral or parenteral administration, are minimized by the rapid rectal route provided by Clysmathane.

Dosage: One Clysmathane (Fleet) Unit as a retention enema before retiring or as directed.

Composition: Theophylline monoethanolamine (Theamin, Fleet), 0.625 Gm.; aqua, 37 ml. in single dose rectal dispenser. Prescription package of six individual units. Manufacturer's label readily removable.

(1) Ridolfo, A. S. & Kohlstaedt, K. G. "A simplified method for the rectal administration of theophylline," to be published.

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The new six-unit PRESCRIPTION PACKAGE of Clysmathane (Fleet) is more convenient to prescribe while assuring an adequate supply for patients. Disposable, single dose squeeze bottle is especially designed for self-administration... ready to use with prelubricated rectal tube. The manufacturer's labels are readily removable.

STOCKBROKERS' COMMISSIONS

office, G.A.G. was offered at 40. He placed an order for 100 shares. He followed this with another order to sell the stock when and if it reached 41. While he was watching the tape, it did hit 41, and the shares were sold.

The doctor gleefully totaled up his profits. Two placid hours in an upholstered leather chair had earned him \$100.

But much of his joy drained away when he got the broker's statement. Commissions on the purchase and sale totaled about \$64, and Federal and state trans-

fer taxes came to another \$10. So he'd made only \$26—and at quite a risk, too. For if he had guessed wrong on the stock and it had *dropped* a point by the time he'd sold, he would still have had to pay about the same commission and taxes.

With a pencil in hand, he then figured out the odds: If he were to do any more such tape reading, he'd need to be right nearly seven out of eight times *just to break even*.

"Some professional traders do very well at this," says one prom-



Round-Lot Commission Rates on Stocks

MONEY AMOUNT OF TRANSACTION	COMMISSION RATE
Under \$100	As mutually agreed
\$100 to \$399	2 per cent, plus \$4
\$400 to \$2,199	1 per cent, plus \$8
\$2,200 to \$4,999	1/2 per cent, plus \$19
\$5,000 and above	1/10 per cent, plus \$39 (maximum: \$75)

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pulse rate up?

Serpasil slows heart rate in most cases of organic or functional tachycardia.

You'll find it especially valuable in cardiac patients whose conditions are aggravated by heart speed-up. Through a unique heart-sloring action, independent of its antihypertensive effect, Serpasil prolongs diastole and allows more time for the myocardium to rest. Blood flow and cardiac efficiency are thereby enhanced.

What's more, you can prescribe Serpasil with confidence. Therapy with Serpasil is virtually free of the dangers (heart block and cardiac arrest) heretofore encountered with heart-sloring drugs. Side effects are generally mild and can be overcome by adjusting dosage.

DOSAGE FOR TACHYCARDIA

Dose range is 0.1 to 0.5 mg. (two 0.25-mg. tablets) per day conveniently taken in a single dose. Rapid heart rate usually will be relieved within 1 to 2 weeks, at which time the daily dose should be reduced. Suppression of tachycardia often persists after therapy is stopped.

NOTE: In patients receiving digitalis or quinidine, Serpasil therapy should be initiated with especially careful observation. Serpasil is not recommended in cases of aortic insufficiency.

SUPPLIED: Tablets, 1 mg. (scored), 0.25 mg. (scored) and 0.1 mg. Elixirs, 1 mg. and 0.2 mg. Serpasil per 4-ml. teaspoon.

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STOCKBROKERS' COMMISSIONS

inent investment man. "But by and large, when doctors switch stocks daily or weekly, they make money only for their brokers."

That statement is more true today than it used to be. Reason: The cost of buying and selling stock has gone up. Last May the New York Stock Exchange raised its schedule of commission rates an average of 13 per cent. (Since then, the American Exchange, the major regional exchanges, and most over-the-counter dealers have followed

suit with similar rate increases.)

The new rates range all the way from a fraction of 1 per cent to 6 per cent of the amount involved in the purchase or sale. Whether you pay at a higher or lower rate depends on the kind of investment you make—the number of shares you buy at a clip, the price per share, and the timing of your purchases and sales.

For the long-term investor, the cost of buying stocks has been and still is small. Even a 6 per cent commission doesn't bulk



Round-Lot Commission Costs by Price of Stock

PRICE OF STOCK	NUMBER OF SHARES BOUGHT	TOTAL INVESTMENT	COMMISSION COST
\$ 1	10,000	\$10,000	\$600
10	1,000	10,000	180
25	400	10,000	126
50	200	10,000	88
100	100	10,000	49



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*ASCRIPtin (aspirin buffered with MAALOX®) "... acts faster and produces higher blood salicylate levels compared with acetylsalicylic acid. It reduces pain more rapidly in arthritic conditions and simple headaches. In addition, patients who suffered from gastric irritation after aspirin were able to take Ascriptin in comparable dosages without any ill effects."¹

¹Clinical and Blood Chemical Studies with Ascriptin.

Feinblatt, T.M., et al. N.Y. State J. Med. 58:697, March 1, 1958.

ASCRIPtin: Acetylsalicylic acid 0.30 Gm., with MAALOX® (magnesium aluminum hydroxide gel) 0.15 Gm., bottles of 100 tablets.

Samples on request.

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STOCKBROKERS' COMMISSIONS

too large if it's averaged out over the five or ten years you may hold the stock. But for the "trader," commissions are a major investment expense that simply can't be ignored.

Naturally, you buy a share of stock because you think it's a good investment, not because you pay a smaller brokerage commission. And if you lose faith in an issue, no matter how long you've held it, the commission won't keep you from selling. Even so, it's wise to know what it costs to buy and sell stock, since such costs affect your potential profits.

If you understand the ins and outs of brokerage commissions, you're likely to choose your investments with a better knowledge of their actual cost. So here are the key facts you should keep in mind:

1. The lower the price of the stock you buy, the higher the commission you pay.

That's because the commission is figured on a graduated scale according to the price of a round lot of 100 shares. The difference in commission between a high-price and low-price stock can be substantial. For example:

Suppose you have \$10,000 to invest in common stocks. You've studied the market and narrowed your choice down to two securities, one selling for \$10 a share and the other for \$100. They look equally promising. Should you buy 100 shares of the \$100 stock or 1,000 shares of the \$10 stock?

Answer: From the standpoint of brokerage fees, the \$100 stock is the better buy. Even though both purchases involve the same dollar amount, the higher-price shares would cost you \$131 less in commissions. It's figured this way:

One hundred shares of a \$10 stock cost \$1,000. The commission on a purchase of that size is 1 per cent of the amount involved, plus \$8. Total brokerage fee for 100 shares: \$18. Total commission for 1,000 shares: ten times \$18—or \$180.

Now contrast this with the commission you'd pay on 100 shares of a \$100 stock. The rate here is only 1/10 of 1 per cent, plus \$39. So your total fee for buying \$10,000 worth of \$100 shares amounts to only \$49.

For a birdseye view of current commission rates, see Table 1 on page 272. And for a good idea of



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Frequently, a single dose of 'Thorazine' (either syrup or suppository) will stop vomiting caused by viral infections and help restore normal food intake and hydration. 'Thorazine' also promotes sound, uninterrupted sleep which is so necessary to recovery.

The high degree of safety with the use of 'Thorazine' in children is a consistent finding in the medical literature.

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STOCKBROKERS' COMMISSIONS

the wide variation in costs depending on the price of the stock, see Table 2 on page 274.

It normally costs you just as much to sell shares as to buy them. But here the short-term trader does get something of a break. That's because of the New York Stock Exchange's "round-trip" rules:

If you sell a stock within fourteen calendar days after buying it, you pay only half the usual commission for the resale, plus \$5 for each round lot of 100 shares (or \$3 for each odd lot of fewer than 100 shares).

2. Odd lots cost you extra in commissions.

To figure out the commission on an odd-lot purchase, you apply the rate for a round-lot purchase of the same dollar amount; then you deduct \$2.

Suppose, for example, you buy twenty shares of a \$50 stock. The total amount involved in the purchase is \$1,000, and the commission rate for such an amount in 100-share lots is 1 per cent plus \$8. That comes to \$18. Subtract \$2, and you get the cost of buying your twenty shares: \$16.

So your odd-lot purchase has cost you 80 cents a share. On a

round lot of the same stock, the commission would be \$44, or 44 cents a share.

As the number of shares in the odd lot increases, the price per share drops. If you buy fifty shares of a \$50 stock, the commission is 59 cents a share. And for ninety-nine shares of the stock, the commission is only about 42 cents a share—even less than that for a round lot.

But don't jump to the conclusion that odd lots may sometimes be cheaper than round lots; they never are. In addition to the regular brokerage commission for an odd lot, you must pay another charge tacked on by the odd-lot brokers who handle your order.

For stocks selling under \$40, this extra charge is one-eighth of a point (12½ cents a share). When you *buy* an odd lot, you pay 12½ cents more per share than its price in the next round-lot transaction after your order is placed. When you *sell* an odd lot, you get 12½ cents less per share than the next round-lot price. For stocks selling at \$40 and over, the extra charge is one-quarter of a point (25 cents).

So the rule about round-lot commissions (the cheaper the stock, the higher the commis-



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goes
a long way
to treat
the
entire cough*



each tasty 30 cc. (1 fl.oz.) represents:

Dihydrocodeinone Bitartrate. 10 mg. (1/6 gr.)
Nembutal® Sodium 25 mg. (5/6 gr.)
Ephedrine Hydrochloride. 25 mg. (1/6 gr.)
Calcium Iodide, anhydrous 910 mg. (14 grs.)

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STOCKBROKERS' COMMISSIONS

sion) doesn't apply completely to odd-lot trading. It's obviously cheaper, as far as the odd-lot extra charge is concerned, to trade in stocks selling below \$40.

3. There are three ways you can avoid paying commissions.

You can't use them on all kinds of purchases, but only on certain kinds. Here are the cost-free possibilities:

¶ *Secondary offerings.* This is

a large block of stock offered for sale after the close of the market at the closing price. For example, an estate that wants to liquidate its holdings might offer to sell 10,000 shares of a given stock at today's final price, so as not to risk having to sell the stock for less tomorrow. The estate then pays the entire commission cost. So you can buy 100 shares, say, through your broker on a commission-free ride. Such second-



"I have to hang up now. The doctor's coming to cut my cast off."



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Each Capsule Contains:

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Niacinamide	100 mg.
Ascorbic Acid (C)	300 mg.
Pyridoxine HCl (B ₆)	2 mg.
Vitamin B ₁₂	4 mcgm.
Folic Acid	1.5 mg.
Calcium Pantothenate	20 mg.
Vitamin K (Menadione)	2 mg.

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BROKERS' COMMISSIONS

ary offerings are announced over the ticker tape. You can ask your broker to keep you posted on them as they occur in stocks you think you might be interested in buying.

¶ **Stock rights.** Companies often issue their stockholders "rights" to buy new shares in proportion to the number they already own. Sometimes the company permits you to exercise such rights directly rather than through a broker. If it does, you avoid paying a commission on the new shares you pick up. Early this year, for example, A.T. & T. offered its stockholders a chance to buy \$100 worth of convertible bonds for every nine shares of stock they already held. And stockholders could send their orders directly to the company.

¶ **No-load mutual funds.** Most mutual funds charge a commission of about 8 per cent when you buy their shares. But a few charge nothing at all. Among the no-load funds are such companies as Scudder, Stevens & Clark; Loomis-Sayles; and the Energy Fund. In effect, when you buy shares of a mutual fund, you acquire a proportionate slice of all the securities in the company's portfolio. In a no-load fund you get it all commission-free. END

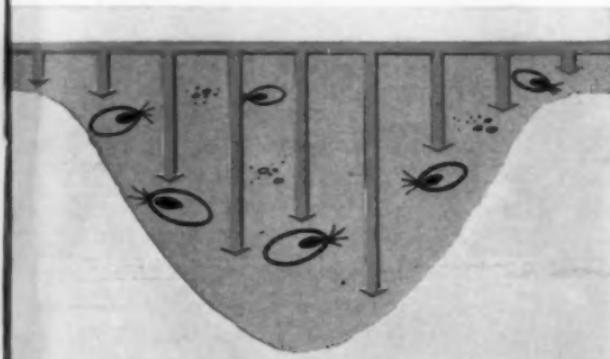
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*Breaks through the
treatment barrier of
vaginal leukorrhea*

SEEKS OUT and EXPLODES the NOMAD TRICHOMONAD

The trichomonad likes to wander. It hides under debris and mucus, and burrows deeply into the crypts and crevices^{1,2} of the vaginal vault "where the albumin normally present acts to protect many of the organisms from surface medication."¹

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from without
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from within

Lycinate, in addition to its surface active medicaments, contains lysing agents which carry the protozoacide-fungicide, Diiodohydroxyquin, through mucopurulent discharge to reach even deep-seated pathogens.

Once in contact, Lycinate dissolves cell membranes, denatures cell proteins, penetrates the pathogens, causing them to swell and explode.

Each tablet contains:

Diiodohydroxyquin.....	100 mg.
Sodium lauryl sulfate.....	5 mg.
Diocetyl sodium sulfosuccinate.....	5 mg.
Aluminum potassium sulfate.....	14 mg.
Lactose.....	380 mg.
Dextrose, anhydrous.....	650 mg.

1. Davis, C. H., and Grand, C. G.: Continued Studies on the Treatment of Trichomonas Vaginalis Infections, *Am. J. Obst. & Gynec.* 68:559 (Aug.) 1954.
2. Weiner, H. H.: Treatment of Trichomonas Vaginitis, *Clin. Med.* 5:25 (Jan.) 1958.

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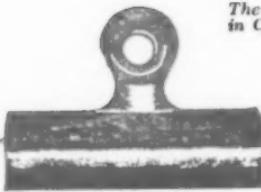
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for healthy tissue metabolism



OFFICE MANAGEMENT MEMO

From Irwin Hoffman, M.D.

The author is an internist practicing in Cedarhurst, N.Y.



Rx for Telephone Interruptions

My office routine used to be interrupted quite often by telephone calls from relatives of my hospitalized patients. I couldn't blame them for wanting to know how the patient was getting along. But in the case of a sick person with a large family, I found that such calls actually took more of my time than treating the patient did.

If you've ever had this problem, you may be interested in my solution. It's this:

Whenever I hospitalize a patient now, I make a note of the *one* relative who seems most responsible and intelligent. I get his phone number, and I tell him I'll call him every day, just after I've seen the patient. Most important, I ask him to pass on these daily reports from me to the other relatives.

It works. I make such telephone calls at *my* convenience, usually just after hospital rounds. The relatives seem to appreciate my taking the initiative. And they no longer call me at the office.

END

Delayed-Action Suits Can Land You in Court

Continued from 85

always do so, as one California case illustrates:

The plaintiff charged she'd suffered severe internal burns as a result of a course of X-ray treatment. She claimed she hadn't discovered the full effect of the damage until long afterward. The court dismissed the suit when it found out what she meant by "long afterward." Her last X-ray treatment had been given eleven years before she'd brought suit!

4. The statute may not start to run until the patient's course of treatment ends—or even until the doctor-patient relationship ends.

In some states, medical treatment is considered "as a whole." That is, if you're treating a patient for a certain condition, the statute doesn't come into effect until after you've finished your entire course of treatment, no matter when the alleged injury occurred. For example:

When a certain Missouri physician set a broken arm in March, 1936, a locked elbow re-

sulted. After six months of treatment, the doctor decided he'd have to operate. Paralysis of the fingers followed; and treatment was continued for another four years without success.

Finally, in 1942, the patient sued. The defendant pleaded that Missouri's two-year statute of limitations barred a suit, since the ill effects stemmed from a 1936 procedure. But the court rejected his plea on the ground that the statute hadn't started to run until the day of the patient's last visit.

New York courts are unusually strict in holding that their two-year statute starts to run on the date of the wrongful act. But even they have made exceptions in the case of *continuing* negligence during a *continuing* course of treatment.

In one such case, a physician left a sponge in the patient's abdomen following surgery to remove a tumor. The doctor continued treatment for two and a half years. Later, the patient sued.

The doctor then insisted that the action was barred by the statute, since the operation had been done more than two years earlier.

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DELAYED-ACTION SUITS

But the court found against the doctor. It maintained that since he'd had a *continuing* duty to repair the wrong done, the patient had a continuing right to sue.

A few states—notably Michigan and Ohio—hold that the statute doesn't start to run until the doctor-patient relationship formally ends. This can be interpreted to mean that as long as the physician remains the patient's doctor, he's liable for any injuries he's done the patient at any time during their relationship.

Even when a malpractice suit is barred by the statute, patients in most states can still sue on the ground that the doctor broke an implied contract by not using ordinary skill.

In some thirty states, the statute of limitations for a breach of contract (even an oral contract) is usually longer than that for malpractice or personal injury. In Missouri, for example, the usual time limit for a malpractice action is two years; for a breach-of-contract action, five years.

More ▶

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Dose: One Nugget per day.
Supplies: Boxes of 20-nugget
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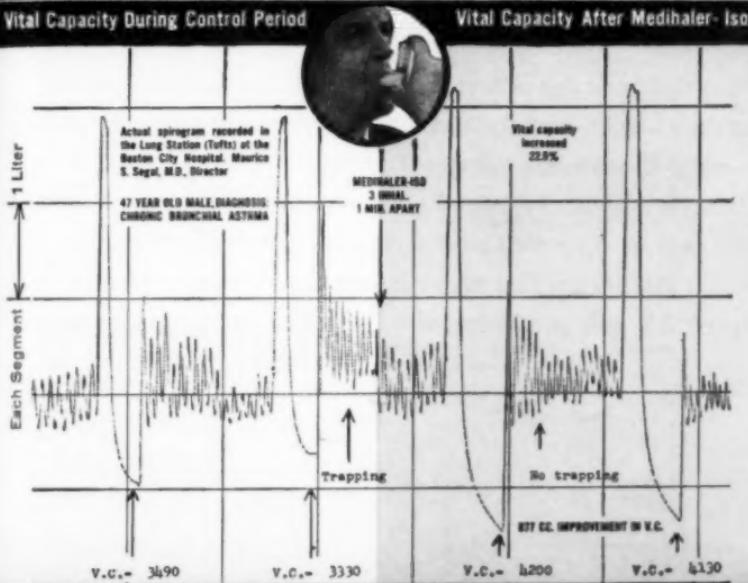
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For quick relief of bronchospasm of any origin. More rapid than injected epinephrine in acute allergic reactions.

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Premicronization assures optimum particle size for maximum effectiveness. Medihaier-Iso is unsurpassed for rapid relief of symptoms of asthma and emphysema. In spill-proof, leakproof, shatterproof vest-pocket size dispensers.

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Northridge, Calif.



This patient's blood-pressure controlled for the first time without side effects

Remember this particular patient. He typifies the thousands of patients involved in a clinical investigation which promises to bring about a major change in rauwolfia therapy. The patient is being treated in a Massachusetts hospital. His blood pressure without treatment ranged up to 220/138; now *for the first time*, it is being maintained near normal *without side effects*. This dramatic case history is part of the story of a remarkable new antihypertensive agent

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DELAYED-ACTION SUITS

It's true that damages in a breach-of-contract case are generally limited to the patient's out-of-pocket expenses. So the awards in such cases are likely to be much smaller than those in malpractice suits. Even so, lawyers are often willing to shoot for the lesser target when the statute of limitations clearly bars them from shooting at the bigger one.

In a recent New York case, for example, a patient belatedly

sued a surgeon who'd left an arterial forceps in the abdomen during an appendectomy. The State Supreme Court threw out the malpractice suit because it had been filed too late. But the patient then sued for breach of contract. The statutory period for such suits is six years in New York, as against only two for malpractice actions.

And the patient won. He was specifically denied recovery for pain or suffering. But the de-



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DELAYED-ACTION SUITS

fendant had to reimburse him for all surgical, hospital, and nursing fees, as well as for drugs and other expenses connected with the operation.

So there you have the five most common exceptions to the general application of the statute of limitations in malpractice suits. There may be additional exceptions in your state. Or there may be none at all (as in Connecticut and Delaware, for instance). Your best safeguard against unforeseen contingencies: When in doubt, consult your attorney. END

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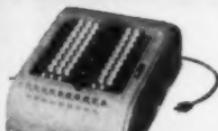
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Will Your Estate Plan Really Work Out?

Continued from 95

another change he planned to make. Rather than leave his estate outright to his wife, he wanted to put most of his assets in a testamentary trust (one that would take effect at his death). That way, he felt, a bank trustee would relieve Mrs. Barnes of all money-management worries.

I advised the doctor against it. Though trusts are often excellent planning devices, I felt that in this case the trust might be pretty small for efficient operation.

Not Worth the Cost

"If you were to die unexpectedly tomorrow," I explained, "your estate wouldn't amount to much more than \$30,000, apart from your life insurance and your home. That may not be enough to justify a trustee fee. Besides, you've told me that Mrs. Barnes has good business sense. Why not leave the management of her money entirely up to her?"

But Dr. Barnes didn't expect to die. He looked forward to long years of estate-building. So

he had his lawyer provide for the trust in his will.

That was four years ago. I never saw the doctor again. But I've met his widow. And I've once more reviewed his financial records.

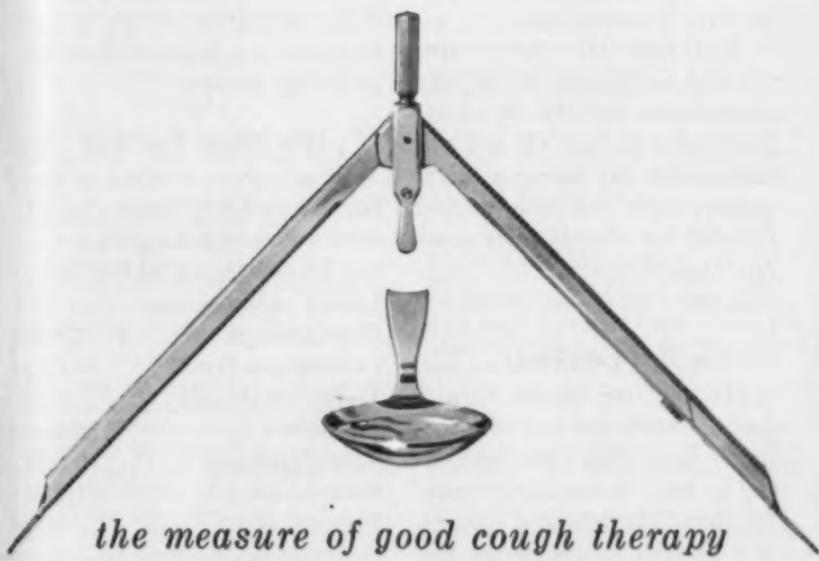
Two weeks after the funeral, Mrs. Barnes wrote and asked me to look over her financial situation. She sent along a huge bundle of documents and arranged to see me a week later.

Headed for Trouble

After spending only a few hours with the papers, I could see that the doctor's widow was in for a bad time. Her husband had gone his own way despite my advice (and perhaps the advice of others).

From 1954 to 1957, he had followed in general the investment-insurance program I'd suggested. But there was one big exception: He kept postponing the purchase of \$50,000 additional life insurance. That was bad enough. Then in December of last year he began tinkering with the coverage he already had.

You'll recall that he'd insisted on taking a \$20,000 term contract at the time I'd urged a



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WILL YOUR ESTATE PLAN WORK OUT?

\$200-a-month family income rider. Last December, he apparently decided I'd been right after all. So he applied for income coverage. But while his application was pending, he foolishly let his term insurance lapse.

And then Dr. Barnes discovered—ironically, in the very examination for the new contract—that he had TB and was uninsurable. By letting his term policies lapse too soon, he had reduced his already inadequate coverage of \$52,500 to a mere \$27,500.

'The Best-Laid Plans . . .'

He took the double blow—loss of health and loss of insurance—with great calm, according to Mrs. Barnes. Obviously, he must have felt he'd soon be well enough to replace the lost insurance. But it didn't work out that way.

His hospital stay stretched into weeks, then months. And in the long illness preceding his death, he made another unwise move. Without consulting his lawyer, he stripped his testamentary trust of most of its assets and endorsed them directly over to his wife. Only the rental real estate of which he

was part owner remained in trust for her.

This meant that the trust now had only \$10,000 in assets. The cost of administering such a trust generally is disproportionately high, since trust company fees may eat up a good third of the property's income.

How Much Was Left

What's the net effect of Dr. Barnes' mistakes? Here's how I summed up the family's financial position to his widow. First I listed all her assets:

Bank accounts	\$ 2,500
Government bonds	26,000
Mutual funds and	
stocks	16,000
Rental property	10,000
Business auto	1,500
Personal auto	500
Overpaid income tax	800
Life insurance	27,500
Residence	25,000
Total	\$109,800

Nothing to Sell

Next I assured her that final illness and funeral costs of \$8,500 would be met by liquidation of the doctor's accounts receivable (about \$6,700) plus disability insurance proceeds of \$2,000. (Since his had been a

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"An Electrocardiograph tracing which fails to show a standardization pulse over a base (isoelectric) line taken while the recording paper is moving, together with a similar pulse placed on each lead, does not assure the interpreter that the recording was made with any degree of accuracy. The standardization pulse reflects the accuracy of both the amplitude and the time duration of complexes."



"Response characteristics of the instrument are of paramount importance. The accuracy of the horizontal portions indicating time duration of the trace is directly proportional to the speed of the vertical movement of the stylus as displayed (rise time) by the standardization pulse. Each millimeter horizontally (at 25 mm. per second paper speed) represents an interval of .04 seconds. A delay of the response of the system, as indicated by the standardization pulse, continuously magnifies errors in measuring the timing in the horizontal trace. The galvanometer must so control the writing of the stylus that in vertical movement there is no overshoot due to velocity or weight, nor over-damping (undershoot), due to stylus-paper friction, inertia of the galvanometer itself, or characteristics of the amplifier."



"A wide base line may be suitable for photographic illustrations in a text but an ECG base line should never be wider than one-half millimeter for fear of destroying important information at various sharp angles of the trace such as at the

'Q' and 'S'. The narrowest (isoelectric) base line possible that is discernible is likely to produce the most revealing trace."



"Since intervals of time as indicated in seconds, or fractions thereof, in millimeters horizontally on the trace are of paramount clinical significance, no ECG can be depended upon unless it is continuously marked to show that the paper traveled underneath the writing stylus accurately at the time set: 25 mm. per second or 50 mm. per second."



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WILL YOUR ESTATE PLAN WORK OUT?

"hospital practice," there was no money to be realized from sale of practice or equipment.)

Finally I discussed her income prospects. She'd probably get about \$175 a month in investment income, I explained. And her meager insurance would pay \$400 a month for the next four and one-half years. This \$575 a month, I figured, would just about meet the family's living expenses.

"And when the insurance money stops?" she asked.

She'd Have to Work

"I estimate that your household expenses won't decrease for the next twelve years," I answered. "So when the insurance money is exhausted, you'll have to get at least a part-time job until the children are out of school.

"I used to be a nurse," said Mrs. Barnes.

"Good. Part-time nursing should bring you in about \$200 a month. Add this to your investment income of \$175 and you have \$375. That's still \$200 short of what you'll probably need. To make up the difference, I suggest you periodically cash in matured Government bonds. You have enough bonds to keep it up till your youngest child is almost through high school."

"But will I still have the stock?"

"Yes. By then it might well be worth much more than its present value of \$16,000—though, of course, we can't be sure. In addition, you'll still own your home. And after working as a nurse for some years, you'll be eligible for Social Security benefits at your retirement."



No College for Them

She thought for a long minute before saying: "Charles always planned on college for the children."

I'd struggled hard over the college problem. But I could find no ready solution. I had to tell her so.

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WILL YOUR ESTATE PLAN WORK OUT?

financial situation had come as a shock to Mrs. Barnes. Instead of going through the child-rearing years on insurance money, she'd have to become a working mother. Instead of living on income, she'd have to liquidate her small capital. But she smiled bravely. "We'll manage," she said.

What Might Have Been

I'm sure she will manage. But it won't be easy. Consider, on the other hand, how she'd have been left had the doctor insured himself properly:

From insurance alone she could have had \$600 a month for the next fourteen years. So she could have reinvested, rather than spent, much of the income and interest from her investments. And she could have financed college educations for the children by selling Government bonds.

When Dr. Barnes worked out his own estate plan, he assumed he'd live for a good many productive years. That's always a dangerous assumption. His widow wishes he'd taken some sound advice.

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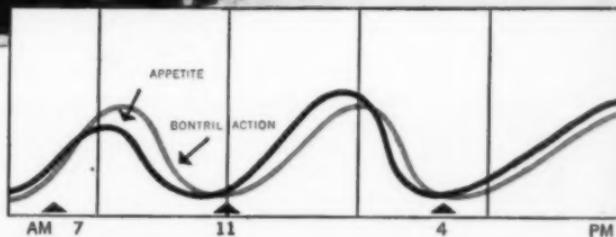
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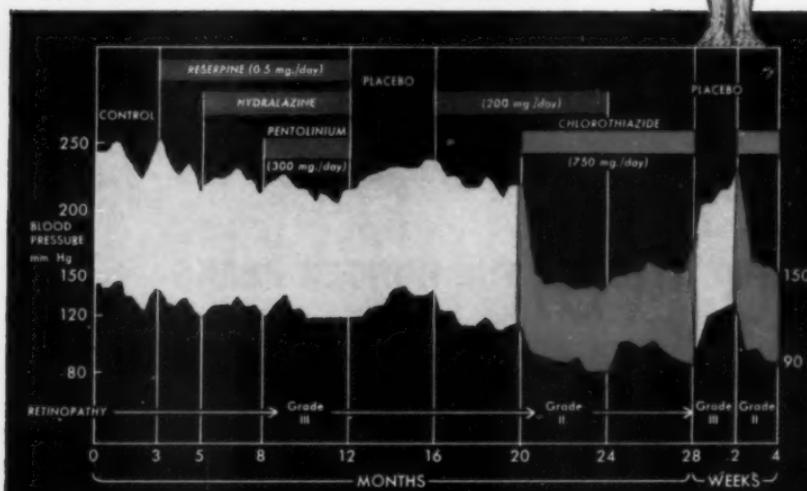
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Wilkins, R. W.: New England J. Med. 257:1026, Nov. 21, 1957.

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Freis, E. D., Wanko, A., Wilson, I. H. and Parrish, A. E.: J.A.M.A. 166:137, Jan. 11, 1958.

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In "Chlorothiazide: A New Type of Drug for the Treatment of Arterial Hypertension,"

Hollander, W. and Wilkins, R. W.: Boston Med. Quart. 8: 1, September, 1957.

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1. Clayman, S. J.: *J. Med. Soc. N. J.* 55:168 (April) 1958.



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¹Brusch, C.A., et al.: Md. State Med. J.; 5:36, 1956.

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Memo

From the Publisher

More Than a Magazine

Most doctors don't just *read* MEDICAL ECONOMICS. They save whole issues, clip out articles, talk about them with colleagues, and *act* on what they read. So Alfred Politz tells us.

Mr. Politz has done intensive readership studies of magazines like Life, Look, Reader's Digest, Saturday Evening Post—and recently, at our invitation, MEDICAL ECONOMICS. As I interpret his studies, the thing that sets this magazine apart is the high proportion of its readers who do more than just read it.

Of all the practicing physicians who read an average issue, according to Politz:

¶ More than 64 per cent save whole issues of MEDICAL ECONOMICS.

¶ More than 45 per cent clip articles out of MEDICAL ECONOMICS for future reference.

¶ More than 55 per cent discuss articles they've read in MEDICAL ECONOMICS with other physicians.

As for acting on the basis of what they read, the doctors interviewed by the Politz organization cite these typical examples:

"MEDICAL ECONOMICS forecast the recession for me, warned me in time to take up the slack in my charge accounts" . . . "I changed my fees—raised some, lowered others—after reading what colleagues were doing" . . . "This office was planned from a diagram in MEDICAL ECONOMICS" . . . "I switched to pictorial case histories after reading how much time they save" . . . "The Ten Best Medical Schools helped me to pick one for my son" . . . "I set up my partnership on the basis of their advice."

If you've been helped in some similar fashion, don't thank us; thank yourself and your fellow readers. You are the ones who have made MEDICAL ECONOMICS more than a magazine. You've made it a swap shop of business ideas, a reference center for practice-connected problems, a national clearinghouse of nonclinical experiences.

A clearinghouse is effective only when those who take from it also give to it. MEDICAL ECONOMICS readers are givers without equal. Thank you in behalf of the beneficiaries: those who act on what they read. —LANSING CHAPMAN